Petition

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No.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY,

Petitioner,

v.

A. ALEXANDER PIRENO,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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Questions Presented

1. Whether the federal antitrust exemption provided by the McCarran-Ferguson Act for the business of insurance applies to the widespread use of peer review by which health insurers solicit advice from health care professionals as to the reasonableness or propriety of certain reimbursement claims under health insurance policies.

2. Whether, as suggested by the decision below, this Court recently has abandoned altogether its previous definition of the business of insurance under the McCarran-Ferguson Act in favor of a much narrower definition which excludes activities involving the interpretation and enforcement of the insurance policy, heretofore considered the "core of the business of insurance."

Parties to the Proceeding Below

In the appeal to the Second Circuit, the respondent, A. Alexander Pireno, was the plaintiff-appellant. The petitioner, Union Labor Life Insurance Company, and the New York State Chiropractic Association were defendants-appellees. The New York State Chiropractic Association is simultaneously filing a separate petition for a writ of certiorari.

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A. ALEXANDER PIRENO,

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

The petitioner, Union Labor Life Insurance Company ("ULL"), respectfully prays that a writ of certiorari issue to review the opinion and judgment of the United States Court of Appeals for the Second Circuit entered on May 28, 1981.

Opinions Below

The opinion of the United States Court of Appeals for the Second Circuit (App. A)[1] is reported at 650 F.2d 387. The opinion of the United States District Court for the Southern District of New York (App. B) is reported at 1979-2 Trade Cases (CCH) ¶ 62,758.

Jurisdiction

The judgment of the United States Court of Appeals for the Second Circuit (App. C) was entered on May 28, 1981. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

Statute Involved

Petitioner seeks the immunity from the respondent's antitrust action provided by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (App. D), which exempts from the federal antitrust laws activities that: (i) constitute the business of insurance; (ii) are regulated by state law; and (iii) do not involve boycott, coercion or intimidation.

Statement of the Case

The Parties

ULL is an insurer organized under the laws of Maryland and licensed in 44 states including New York (J.A.

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[1] Parenthetical references preceded by "App." refer to the Appendices to this Petition.

6; R.42,[2] O'Connor Affidavit at 2). As a licensed accident and health insurer in New York, where the events complained of took place (1979-2 Trade Cases [CCH] at 78,377; App. B at 31a), ULL's activities are extensively regulated under the provisions of the New York Insurance Law (*see* arts. 4, 7, 7-A, 9-A and 9-D) and the regulations promulgated thereunder by the Superintendent of Insurance of the State of New York ("the Superintendent") (State of New York, Official Compilation of Codes, Rules and Regulations tit. 11). The regulation applies, among other things, to the form and content of ULL's insurance policies and its premium charges and claim settlement practices.

The New York State Chiropractic Association ("NYSCA") is a nonprofit New York corporation functioning as a professional association for chiropractors. NYSCA administers the peer review committee utilized by ULL and complained of by Pireno (J.A. 23). Members voluntarily serve on the peer review committee as a public service (J.A. 35, 46; 1979-2 Trade Cases [CCH] at 78,374, App. B at 22a). The peer review service is available to patients, governmental agencies, insurers and even chiropractors themselves should a dispute arise between the chiropractor and the insurer or patient (J.A. 53; 650 F.2d at 388, App. A at 4a).

The respondent, A. Alexander Pireno ("Pireno"), is a chiropractor licensed and practicing in New York. The necessity and propriety of the treatments rendered by Pireno to ULL insureds and the fees charged for such

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[2] Parenthetical references preceded by "J.A." refer to pages of the Joint Appendix on the appeal to the Second Circuit. Parenthetical references preceded by "R." refer to the document number of the Index to the Record on Appeal to the Second Circuit.

treatments were evaluated on at least four occasions by the NYSCA peer review committee, at the request of both Pireno and ULL (J.A. 66; 1979-2 Trade Cases [CCH] at 78,375, App. B at 25a).

Peer Review as an Essential Aid in the Interpretation and Enforcement of the Insurance Policy

The New York Insurance Law was amended in 1971 to require accident and health insurers to reimburse insureds for chiropractic as well as other medical treatment (1971 N.Y. Laws ch. 983, codified in N.Y. Ins. Law § 221[5][e] [McKinney Supp. 1980]). Thereafter, attempting to comply with the coverage, rating and claim settlement mandates of the New York Insurance Law and the Superintendent's regulations, ULL began to request the NYSCA peer review committee to review certain chiropractic treatment reimbursement claims. The soliciting of the peer review advice was necessary because of questions relating to whether some treatments were necessary or appropriate or whether certain fees charged were reasonable or customary so as to be within the coverage limits of ULL's policies.

ULL's policy forms, filed with and approved by the Superintendent, include the following limitations of coverage for medical treatment: (1) the treatment must be within the scope of the doctor's license to practice; (2) the treatment must be for accidental injury or sickness unrelated to the occupation of the insured; (3) reimbursement under the major and supplemental coverages is limited to "the reasonable charges . . . for necessary medical care and services" and the "regular and customary charges for the services and treatment furnished" (R.42, O'Connor Affidavit at 4, Exs. B, C).

NYSCA's peer review committee upon request evaluates both the necessity and propriety of the treatment rendered and the reasonableness of the fees charged (J.A. 50-52; 650 F.2d at 388, App. A at 4a). However, the insured, insurer, and chiropractor are not bound by the decision of the peer review committee. As accurately noted by the District Court:

> [A]fter the Committee renders its opinion the insurer remains free to reject it and make its own determination of its liability under its policy. Moreover, absent his consent to a binding determination, the patient remains free to contest the insurer's evaluation of the "reasonableness" of his claim and may bring suit to enforce the terms of his policy. . . . If the chiropractor does not accept an . . . assignment, of course, the patient is obligated to pay the chiropractor's entire fee notwithstanding the refusal of the insurer to pay all or part of the claim.

1979-2 Trade Cases (CCH) at 78,375; App. B at 24a-25a.

ULL's experience with peer review has been that the chiropractors who volunteer to serve on the committee are well qualified with substantial practice experience and represent a cross-section of different theories of treatment and practices in various localities. The affidavit of Raymond V. O'Connor, Vice President and Counsel of ULL, verified that "the committees have provided an essential expertise in the interpretation and application of the policy coverages and limits outlined above" (R.42 at 6).

The Proceedings Below

The District Court

Pireno commenced this action against ULL and NYSCA[3] in September, 1976 seeking declaratory and injunctive relief and damages for an alleged violation of section 1 of the Sherman Act, 15 U.S.C. § 1, and for defamation. Pireno contends that ULL's utilization of NYSCA's peer review committee has acted to limit chiropractic fees and restrain trade. However, he claims no loss of patients (R.33, R.34, Pireno deposition at 102, 138, 141; R.44, Pireno deposition at 48, 56, 57) and no loss of income (R.33, Pireno deposition at 70, 104, 108; R.44, Pireno deposition at 48, 67-69; R.45, Pireno Answer to ULL Interrogs. 1 and 3).

After extensive discovery proceedings by the parties, ULL and NYSCA each moved for summary judgment. The District Court granted the motions and dismissed Pireno's claims, holding that petitioners' peer review practice is covered by the exemption from antitrust suits provided by the McCarran-Ferguson Act.

The District Court carefully analyzed the facts in relation to this Court's decisions in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979)

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[3] The District Court held that jurisdiction existed under 28 U.S.C. § 1337 (1979-2 Trade Cases [CCH] at 78,374; App. B at 21a). Pireno also named the International Chiropractors Association ("ICA") as defendant. After the District Court granted summary judgment to ULL and NYSCA, the action against ICA was dismissed with prejudice pursuant to a stipulation so ordered by the District Court. ICA did not participate in the appeal to the Second Circuit. (650 F.2d at 389-90 n.4; App. A at 7a n.4).

and *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969).[4] The court determined that ULL's use of peer review fits squarely within the "business of insurance" exemption contained in section 2(b) of the McCarran-Ferguson Act as interpreted by this court. The court differentiated peer review from the provider agreements in *Royal Drug* as follows:

> In the instant case, by contrast, ULL's insureds are intimately and directly concerned with the peer review arrangement between ULL and the NYSCA's Committee. Unlike the agreement between Blue Shield and participating pharmacies, the peer review arrangement between ULL and the Committee serves to define the precise extent of ULL's contractual obligations to its insureds under their policies. Peer review may enable ULL to reduce its costs, but it does so through interpretation of the contractual relationship between insurer and insured. Determination of the rights of an insured under his policy is the "core of the business of insurance." Peer review, moreover, involves the spreading of risk, an indispensable element of the "business of insurance." The defendants determine the extent to which an individual insured must bear the full cost of chiropractic services, or instead

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[4] In *Royal Drug*, this Court held that "provider agreements" that fixed the price of products sold by participating pharmacies to subscribers of a health services plan, and which served only to minimize the insurer's costs, were not the "business of insurance" within the meaning of the McCarran-Ferguson Act exemption. In *National Securities*, this Court set out the definition of the business of insurance, stating that "the relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.'" 393 U.S. at 460. See discussion at Point II *infra*.

> have that cost borne by the insurer (and, through higher premiums, his fellow insureds). The Committee's role in evaluating claims submitted for review is thus akin to that played by the licensed adjuster, long an important figure in the settlement of claims against insurers. The court thus concludes that ULL and the Committee are engaged in the "business of insurance."

1979-2 Trade Cases (CCH) at 78,377; App. B at 29a-31a (citations omitted).

The District Court determined that regulation and supervision of health insurers under the New York Insurance Law and the New York antitrust law provides the state regulation required by section 2(b) (*id.* at 78,377-78; App. B at 31a-32a). The court noted also that Pireno's complaint failed to allege that peer review constitutes "boycott, coercion or intimidation" so as to come within the exception to the exemption contained in section 3(b) of the McCarran-Ferguson Act, or even to allege facts which fall within the scope of that exception (*id.* at 78,-378-79; App. B at 33a-36a).[5]

The Court of Appeals

A three-judge panel of the United States Court of Appeals for the Second Circuit unanimously reversed the order of the District Court and remanded for further proceedings.

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[5] Upon the infirmity of Pireno's federal antitrust claim, the District Court dismissed Pireno's state defamation claim for lack of subject matter jurisdiction (1979-2 Trade Cases [CCH] at 78,379; App. B at 36a-37a).

The Second Circuit concluded that this Court in *Royal Drug*, notwithstanding its explicit repetition of the definition of the "business of insurance" laid down in *National Securities*, intended to abandon that definition in favor of a much narrower definition which restricts the "business of insurance" only to an activity which either transfers risk from insured to insurer or spreads the risk among insureds. Applying this analysis, the court determined that peer review is not part of the "business of insurance" because it is only "an aid in determining the scope of the transfer after it has been made" (650 F.2d at 393; App. A at 15a).

The Second Circuit further concluded that *Royal Drug* excluded from the "business of insurance" activities which are "simply a form of cost reduction" (*id.*). Since the court perceived peer review as serving only to reduce costs, it ruled that an insurer's use of peer review is not entitled to the McCarran-Ferguson Act antitrust exemption.

The Second Circuit found it unnecessary to rule on the two other components of the exemption, the sufficiency of the regulation of peer review by the State of New York and the boycott exception.[6]

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[6] Since Pireno did not appeal the dismissal of the defamation claim, the court made no ruling concerning it.

REASONS FOR GRANTING THE WRIT

I.

The Decision of the Second Circuit Directly Conflicts with a Decision by the Fourth Circuit on the Identical Issue Requiring a Resolution by this Court.

The Second Circuit specifically acknowledged that its opinion below conflicted with a recent decision of the Fourth Circuit: "We adhere to this conclusion even though the Fourth Circuit recently reached a contrary result in a factually identical case, *Bartholomew v. Virginia Chiropractic Association, Inc.*, 612 F.2d 812 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980)." (650 F.2d at 395 n.13; App. A at 18a n.13).

The Fourth Circuit in *Bartholomew* held that health insurers who consulted peer review committees of professional chiropractic associations, as well as the associations and individual chiropractors who served on the committees, were engaged in the "business of insurance" so as to be exempted by the McCarran-Ferguson Act from the federal antitrust laws. The court discerned the distinction between peer review and the provider agreements in *Royal Drug*. In so doing, it cited with approval the opinion of the District Court in the present action:

> This conclusion does not trespass upon the teachings of *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed. 2d 261 (1979). In that case there were two segregated and disparate operations: one, the offering of insurance, and the other, the procurement of drugs, admittedly an act only thinly tangential to insurance. Obtaining drugs under the Pharmacy

> Agreement was a business of the insurance companies, not the business of insurance. *Royal Drug* at 218, 99 S.Ct. 1067, n.18. In the present instance, there is an integration of component acts resulting in a single, composite business-insurance. For an especially clarifying discourse of this and the related issues *see generally Pireno v. New York Chiropractic Ass'n,* No. 76-4309 (S.D.N.Y. March 15, 1979).

612 F.2d at 817.

The intercircuit conflict has created widespread confusion and uncertainty. Health insurers, policyholders and medical practitioners throughout the nation have availed themselves of professional peer review services in order to resolve questions of insurance policy coverage. As discussed at Point III *infra,* there is no practical alternative to determine the appropriateness and necessity of treatment and reasonableness of charges in certain individual cases. The decision of the Second Circuit exposes both health insurers and medical professionals who volunteer to serve on peer review committees to the enormous burdens, risks and costs of antitrust litigation. If allowed to stand, it will have a chilling effect on the availability and use of peer review.

There is even now at least one other action pending in a federal district court involving the identical issue of whether a health insurer and chiropractic association are subject to antitrust suits based on the insurer's utilization of peer review. A motion to dismiss has been made in that case based on the McCarran-Ferguson exemption. *Gerimonte v. Washington State Chiropractors Association,* Civil Action No. C81-40R (D. Wash., filed January 23, 1981).

Furthermore, the issue raised by the present petition has not been mooted. There has been no interim amendment or repeal of the McCarran-Ferguson Act, and there is no recent decision by this Court nor case pending before this Court wherein the issue raised by this petition was or will be resolved.

Since the date of the Second Circuit's opinion below, this Court in *National Gerimedical & Gerontology Center v. Blue Cross of Kansas City,* —— U.S. ——, 101 S.Ct. 2415 (1981) considered the effect of the federal antitrust laws on health care services. However, the decision in *National Gerimedical* is limited to a refusal to deal on the part of a provider of health care reimbursement plans based on the applicant hospital's failure to obtain approval from a local Missouri "health system agency" designated under the National Health Planning and Resources Act of 1974, 42 U.S.C. §§ 300k *et seq.* This Court held that said Act was not so incompatible with antitrust concerns as to create a "pervasive" repeal of the antitrust laws as applied to every action taken in response to the health-care planning process.

The issue raised by the present petition arises from an entirely dissimilar factual situation and involves an explicit "business of insurance" antitrust exemption mandated by Congress in the McCarran-Ferguson Act. Accordingly, *National Gerimedical* provides no guidance with respect to the conflicting decisions of the Second and Fourth Circuits regarding peer review.

Certiorari recently has been granted in another case involving the relation of the federal antitrust laws to health care services. *Arizona v. Maricopa County Medical Society,* 643 F.2d 553 (9th Cir. 1980), *cert. granted,* —— U.S. ——, 101 S.Ct. 1512 (1981) involves the set-

ting by a medical society of maximum fees that physician members of foundations for medical care can claim for health services provided to policyholders of pre-paid health insurance plans. The narrow issue before this Court is whether the setting of the maximum fee schedule is a *per se* violation of the Sherman Act.

Unlike *Maricopa,* the issue on the present petition involves no setting of maximum fee schedules, no fixed limitation of reimbursement for medical services, no binding determination by the professional association, and no delegation by the insurer of its responsibility to decide the extent and amount of claims to be reimbursed. ULL seeks only advice from the professional peer review committee in determining its policy obligations. In so doing it is operating entirely within the realm of the "business of insurance" and its activities therefore are expressly exempted from antitrust challenge by the provisions of the McCarran-Ferguson Act.

In sum, the unresolved conflict between the Fourth and Second Circuits concerning the relevant and important issue raised by this petition justifies the issuance of the writ of certiorari. *See Royal Drug,* 440 U.S. at 208.

II.

By Narrowly Defining the "Business of Insurance" to Exclude a Health Insurer's Use of Peer Review the Second Circuit Has Erroneously Departed from this Court's Construction of the McCarran-Ferguson Act.

In addition to the direct conflict between the circuits, certiorari is necessary to clarify the confusion regarding the meaning of the "business of insurance" which has been created by the Second Circuit's decision below. The

Second Circuit read *Royal Drug* to abandon the long accepted and generally understood definition of the "business of insurance" set out in *National Securities*. The court suggests that many common insurance practices, which are extensively regulated by the states—such as adjustment and settlement of losses—are no longer to be deemed part of the "business of insurance." Indeed, the decision inexorably leads to the conclusion that all efforts of insurers relating to enforcement and interpretation of insurance policies—where the effect tends to contain costs—are subject to the substantial risks, burdens and cost of antitrust litigation.

National Securities is the seminal case defining the "business of insurance." This Court there formulated the basic criteria for assessing whether conduct constitutes the "business of insurance" as follows:

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, *interpretation, and enforcement*—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder.

393 U.S. at 460 (emphasis added).

Royal Drug, a subsequent case, determined that "provider agreements" that fixed the price of products sold by participating pharmacies to the subscribers of a health services plan were not the "business of insurance" within the meaning of the McCarran-Ferguson Act section 2(b)

exemption. The Court found it necessary to distinguish between an insurance contract and a provider agreement. The former is between insurer and insured and includes the essential elements of underwriting and spreading of the policyholder's risk. The latter is between the insurer[7] and a seller of goods or services and involves no underwriting or spreading of risk; it serves only to minimize the insurer's costs in fulfilling its specified underwriting obligations. The provider agreement, therefore, was deemed to be no different than countless other business contracts of insurance companies designed to keep their costs low.

This Court in *Royal Drug* then went on to say: "*Another* commonly understood aspect of the business of insurance *relates* to the contract between the insurer and the insured." (440 U.S. at 215, emphasis supplied). The decision thereupon repeats the criteria in *National Securities* quoted above. Since the provider agreements did not relate to the interpretation and enforcement of the relationship between insurer and insured, but merely provided for the purchase of goods, they were held not to meet this other test of the business of insurance.

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[7] The decision of this Court in *Royal Drug* did not concede that health care organizations such as Blue Cross are "insurers." *See* 440 U.S. at 226-27 n.34, 230 n.37. This Court regarded it as "highly significant in ascertaining Congressional intent" that such organizations were not commonly understood at the time of enactment of the McCarran-Ferguson Act to be engaged in providing insurance. 440 U.S. at 227. It cannot be disputed that the ULL policies at issue, being the traditional indemnity policies and paying money directly to the insured for his loss, would have been considered by Congress at the time of the passage of the McCarran-Ferguson Act to be the "business of insurance." Nor can it be seriously argued that the ULL policies do not constitute the "business of insurance" in the current "ordinary understanding" of that phrase.

The Second Circuit in the decision below erroneously read *Royal Drug* as abandoning the criteria set out by this Court in *National Securities,* stating: "We think, however, that *Royal Drug* sets forth a substantially narrower scope for the 'business of insurance' exemption than its approving citation of *National Securities* might suggest." (650 F.2d at 394; App. A at 17a).

Nothing in this Court's decision in *Royal Drug* supports the rejection of the *National Securities* criteria for defining the "business of insurance." This Court simply concluded in *Royal Drug* that the pharmacy agreements did not meet those criteria because they were not agreements between insurer and insured and because the only argument advanced by Blue Shield—that the pharmacy agreements related to the company's "status as a reliable insurer" since they reduced costs—went too far, in that such a construction would mean that "almost every business decision of an insurance company could be included in the 'business of insurance.'" (440 U.S. at 216-17). This Court also was influenced by the fact that the pharmacy agreements had a "wholly separate nature" from the insurer's obligations under the policy and involved matters with which insureds are "basically unconcerned." (440 U.S. at 214, 215 n.11, 216 n.14).

The situation is entirely different with respect to peer review. Peer review directly involves the "interpretation" and "enforcement" of the insurance contract and has no other function separate from the implementation of the insurance contract. Peer review certainly cannot be said to involve matters with which policyholders are "basically unconcerned." It goes to the very heart of the policyholder's concern—the amount of reimbursement forthcoming under the terms of the insurance contract. Nor can it be said that peer review is merely a cost-

reduction device indistinguishable from countless other ways in which insurance companies can save money. To the extent peer review helps reduce costs, it does so solely by aiding in the implementation of the insurance policy limits. Hence, unlike the pharmacy agreements in *Royal Drug*, it cannot be said that including peer review within the "business of insurance" would expand the exemption to every business decision of an insurance company. Peer review relates entirely to the interpretation and enforcement of the insurance contract and is, therefore, within the "core" of the "business of insurance" as defined in both *National Securities* and *Royal Drug*.

The Second Circuit's decision is also based on a second fundamental misreading of *Royal Drug*. It gives the test of underwriting and risk-spreading used by this Court, as one definition of the "business of insurance," an unduly narrow construction in applying it to peer review. Thus, the Second Circuit states:

> Nor does [peer review] transfer risk. The risk that an insured will require chiropractic treatment has been transferred from the insured to the insurer by the very purchase of insurance. Peer review takes place only after the risk has been transferred by means of the policy, and then it functions only to determine whether the risk of the entire loss (the insured's cost of treatment) has been transferred to the insurer—that is, whether the insured's loss falls within the policy limits. Peer review is thus not a means of transferring risk from insured to insurer. At most, it is an aid in determining the scope of the transfer after it has been made.

650 F.2d at 393; App. A at 14a-15a.

Later, the Second Circuit states that peer review does not transfer risk but "on the contrary, peer review merely measures the extent to which a policyholder has failed to effect such a transfer." (*Id.*; App. A at 15a).

This Court's opinion in *Royal Drug* provides no basis for such semantic and unrealistic distinctions. It is inconceivable that Congress would have included risk transfer within the "business of insurance" but excluded a device which helps "determine whether the risk . . . has been transferred" and acts as "an aid in determining the scope of the transfer." This is particularly true inasmuch as the underwriting and risk transfer decisions reflected in policy provisions limiting reimbursement to "reasonable" and "customary" charges—flexible concepts which can vary over time and from community to community—do not become concrete until applied to specific claims through claims settlement procedures such as peer review. And, of course, peer review not only helps determine the extent to which risk is not transferred, but the extent to which risk *is* transferred. Even viewed in the light of the Second Circuit's characterization, peer review is a device which helps implement and make meaningful the underwriting, risk-spreading and risk transfer decisions reflected in the insurance policy. As such, peer review is an integral part of the underwriting process not logically distinguishable for purposes of applying the exemption for the "business of insurance."

A third fundamental error in the Second Circuit's reasoning is its conclusion that peer review is outside the "business of insurance" because it is "simply a form of cost reduction." (650 F.2d at 393; App. A at 15a). This aspect of the Second Circuit's decision is also based on a misreading of *Royal Drug*. *Royal Drug* involved agreements between Blue Shield and pharmacists fixing the

price of drugs sold by the pharmacists to Blue Shield subscribers. The Supreme Court concluded that these contracts were outside the "business of insurance" because they were "merely arrangements for the purchase of goods and services." (440 U.S. at 214). The defendants argued, however, that the pharmacy agreements should nevertheless be considered the "business of insurance" because those agreements permitted the insurance company to reduce its costs in fulfilling its obligations to its insured, which in turn, resulted in lower premium charges to insureds. This Court rejected that argument, concluding that if it were accepted, then no rational line could be drawn between the pharmacy agreements and "countless other business arrangements that may be made by insurance companies to keep their costs low and thereby also keeping low the level of premiums charged to their policyholders." (440 U.S. at 215).

Thus, *Royal Drug* simply rejects the argument that a practice comes within the "business of insurance" merely because it serves to reduce costs. But it does not follow that if a practice tends to reduce costs, it is, for that reason, outside the "business of insurance." If this were so, then typical provisions in the insurance contract which function to reduce claims costs would automatically fall outside the "business of insurance." Indeed, most provisions which can be characterized as underwriting, risk-spreading or risk transfer provisions are designed to reduce costs. This is the obvious function of such typical insurance contract provisions as coverage deductibles, underwriting exclusions, co-insurance factors and risk limitations. Certainly, the Supreme Court never intended to suggest that such insurance policy provisions fall outside the "business of insurance" because their function is "merely to reduce costs."

Furthermore, it is untrue, as the Second Circuit concluded, that peer review always results in a reduction of the insurer's costs. The function of peer review is to aid in assuring that the insurance contract benefits and limitations are enforced fairly and in accordance with the customary and reasonable standards set forth in the policy terms. Thus, the peer review process may provide information to the insurer which will result in full reimbursement of a policyholder's claim that otherwise would not have been paid. In such circumstances, peer review obviously does not reduce the insurer's costs.

In some cases, peer review may help reduce costs in the manner described by the Second Circuit: by aiding in proper policy interpretation, it may avoid payment of charges and treatments that fall outside the policy limits. It also permits more precise enforcement of the policy limitations, thus helping to minimize increases in the cost of medical services indemnified by the insurance contract. (650 F.2d at 393; App. A at 15a-16a). But reducing costs in this way is the very essence of the "business of insurance" because it helps carry out the underwriting decisions written into the insurance contract by more precise "interpretation" and "enforcement" of the policy. Unlike the pharmacy agreements in *Royal Drug*, it cannot be said that the cost-reduction function of peer review is indistinguishable "from countless other business arrangements" by which the insurance company purchases goods and services.

A fourth fundamental flaw in the Second Circuit's reasoning is the suggestion, which logically results from the position taken by the court, that claims settlement and adjusting are not within the "business of insurance" as interpreted by this Court in *Royal Drug* (650 F.2d at 394-95; App. A at 18a). This undoubtedly will shock

the "ordinary understanding" of the public, insurance experts, policyholders, and state insurance regulators. Insurance claims settlement and adjustment practices are extensively governed by state statutory and regulatory schemes (*see, e.g.*, N.Y. Ins. Laws §§ 40-d and 273 [McKinney Supp. 1980] [prohibiting enumerated unfair claim settlement practices]).

A recent decision of a federal district court in *Proctor v. State Farm Mutual Automobile Insurance Co.*, 1980-81 Trade Cases (CCH) ¶ 63,591 (D.D.C. 1980), *appeal docketed* (D.C. Cir. November 14, 1980) seems directly at odds with the Second Circuit in this respect. *Proctor* was among the cases before this Court when *Royal Drug* was decided. This Court remanded the case in light of *Royal Drug* and on remand the district court held that the McCarran-Ferguson exemption still applied.

One aspect of the agreement alleged in *Proctor* was neither between carrier and provider nor between carrier and subscriber, but a horizontal agreement among carriers to pay insureds' repair shop claims on the basis of the prevailing labor rate in accordance with a common formula. The district court said that the horizontal agreement was "directly related to the insurance relationship between the insurer and insured and involves claims procedures, which are an important determinant of commonly made rates and the spreading of risks." *Id.* at 77,139. To support its reasoning, the court cited the Department of Justice's *amicus* brief in *Royal Drug*, which agreed with the earlier Court of Appeals decision in *Proctor* that horizontal agreements "concerning the extent to which particular claims would be paid" were exempt under McCarran-Ferguson. *Id.* at 77,140 (quoting Brief of United States as *Amicus Curiae* at 31); *see Proctor v. State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262 (D.C. Cir. 1977), *vacated*, 440 U.S. 942 (1979).

Indeed, the insurance contract traditionally has been viewed as not fully executed until payment by the insurer of a sum after a loss that is covered by the contract. 1 Couch on Insurance 2d § 1:5 (1959).

One commentator's reading of *Royal Drug* is manifestly contrary to the suggestion made by the Second Circuit:

> Claims adjusting is within the *Royal Drug* definition of the business of insurance because the decisions of the adjuster determine who shall bear the loss. Hence, the adjuster's decisions "involve" the underwriting of risk in a fundamental way: they are a culmination of routine practices expressly designed to determine whether the loss falls within the class of risks that the insurer underwrote on the issuance of the policy. Moreover, claims adjusting is the business of insurance because the adjuster's decisions interpret the contractual obligations of insurer and insured by determining the extent of the insurer's liability. Such decisions intimately affect the contractual relationship between the two parties, thus satisfying the second aspect of the business of insurance under *Royal Drug*.

Comment, *The Scope of the "Business of Insurance" Provision of the McCarran-Ferguson Act: Virginia Academy v. Blue Shield of Virginia*, 65 Minn. L. Rev. 1187, 1202 (1981).

The District Court's decision below recognized that members of peer review committees do not play the role of "providers"—such as the sellers in *Royal Drug*; instead, they play a role akin to that played by the licensed adjuster, long an important figure in the settlement of disputes between the insurer and insured (1979-2 Trade

Cases [CCH] at 78,377; App. B at 30a). Both adjusters and peer review committee members should be considered to be engaged in the "business of insurance" when performing their proper functions.

For these reasons, ULL submits that the Second Circuit's decision reflects an incorrect reading of *Royal Drug* and that the correct reading is reflected in the Fourth Circuit's contrary decision in *Bartholomew,* holding that peer review is the "business of insurance" within the meaning of the McCarran-Ferguson antitrust exemption. This Court should grant certiorari to dispel the widespread confusion created by the Second Circuit's decision.

III.

The Decision of the Second Circuit is Likely to Have a Chilling Effect on Peer Review for which there is No Practical Alternative in Insurance Policy Interpretation and Enforcement.

It seems obvious that medical professionals and their associations will be unwilling to volunteer their services for peer review if as a result they may be subjected to the tremendous burdens and costs of federal antitrust litigation. Nor will health insurers be anxious to risk such an exposure. The unfortunate consequence is likely to be the virtual termination of peer review as a means of interpreting insurance policy benefits. The possible alternatives for achieving this essential function either are impractical or themselves subject to federal antitrust challenge under the rationale of the Second Circuit's decision.

Insurer claim personnel normally can determine the propriety of reimbursement claims based on experience

with similar medical treatments. Nevertheless, the immense variety of human physical ailments frequently compels varying and nonstandard types of treatment, at times by highly specialized practitioners.[8] In addition, rapidly changing technology can result in drastic innovations in types, methods and costs of treatment. Moreover, fees may vary substantially based on the locale of the doctor's practice. It would be unreasonable in the extreme under these circumstances to expect insurance company claim personnel to be able to pass on all reimbursement requests without benefit of expert advice.

Equally unreasonable would be to expect a single chiropractor, if retained by the insurer, to be knowledgeable about all types of patient ailments, schools and methods of treatment, newly adopted practices and procedures and geographic variations. Such a chiropractor, therefore, undoubtedly would find it necessary to confer with a number of his colleagues, thereby informally instituting a peer review process without the reliability and safeguards of the peer review process presently available from medical professional associations. Furthermore, this informal type of peer review presumably would encounter the same antitrust challenge which the Second Circuit has authorized in its decision below.

Health insurers similarly would be unable to consult other insurers to determine whether in their experience certain claims for reimbursement are appropriate. Such a course, according to the rationale of the Second Circuit's decision, would not be part of the "business of

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[8] The lack of standardization is particularly prevalent in chiropractic where there are different "schools" or methods in approaching particular medical conditions. *See, e.g.*, B. J. Palmer, The Subluxation Specific—The Adjustment Specific 18-27 (1934).

insurance" and thus would involve the substantial risk of federal antitrust litigation. It might be suggested that ULL could adopt a schedule of fee benefits, by specific dollar amounts, for all treatments, thereby supposedly avoiding problems with interpretation of "reasonable" or "regular and customary" charges. Assuming that such a schedule could be devised for the multifarious forms of chiropractic treatment, there still would be questions as to whether certain treatments were "necessary" or arose from "non-occupational accidental bodily injuries" or were rendered "within the scope of the [doctor's] license" to practice (R.42, O'Connor Affidavit at 4, Exs. B, C).[9] Such a fee schedule would require frequent amendments to the policy which in each instance would have to be approved by the Insurance Department. Furthermore, it is difficult to conceive how either the insured or his doctor would be in a better position with a policy-fixed ceiling on fees rather than with the full benefits for customary and reasonable charges presently provided by the policy provisions approved by the Insurance Department.

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[9] Even where fee schedules have been adopted, it has been necessary to provide for corresponding peer review. For example, the New York Superintendent of Insurance after adopting detailed fee schedules relating to reimbursement of medical costs of "no-fault" claimants, found it necessary to promulgate a regulation providing for professional peer review of "whether fees are in accordance with or not specifically covered by the fee schedules promulgated in Part 68 of this Title (Regulation 83), whether treatment, services or hospitalization was excessive or unnecessary, disputes involving fees in excess of the fee schedule, and whether treatment was related to the injury sustained in the motor vehicle accident." State of New York, Official Compilation of Codes, Rules and Regulations tit. 11, § 65.16(c)(3)(ii). *See also id.*, tit. 12, pts. 328, 342 and 347 (similar regulations promulgated to resolve similar disputes in relation to fee schedules under workers' compensation regulations).

Peer review enables the insurance company to underwrite full benefits for the insured's medical costs based on a flexible standard that allows for changes resulting from, among other things, inflation, new developments in practices and procedures and geographic variations. Peer review advice also helps to resolve differences between insurer and insured that otherwise might lead to litigation or arbitration which would be both unduly expensive in relation to the amounts involved and harmful to the continued underwriting relationship between insurer and insured.

Since there thus is no realistic alternative, peer review is an essential element in health insurers' underwriting practices and in the interpretation and enforcement of insurance policies. It clearly therefore is "the core of the business of insurance" and should not be subject to the chilling effect of federal antitrust challenge.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that this petition for a writ of certiorari should be granted.

Respectfully submitted,

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[Appendices Follow]

Appendix

APPENDIX A

Opinion of the United States Court of Appeals for the Second Circuit

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 245—September Term, 1980

(Argued October 29, 1980 Decided May 28, 1981)

Docket No. 80-7507

A. ALEXANDER PIRENO,

Plaintiff-Appellant,

—v.—

NEW YORK STATE CHIROPRACTIC ASSOCIATION and UNION LABOR LIFE INSURANCE COMPANY,

Defendants-Appellees.

Before:

KAUFMAN, KEARSE, and BRIGHT,*
Circuit Judges.

* Honorable Myron H. Bright of the United States Court of Appeals for the Eighth Circuit, sitting by designation.

Appendix A

Appeal from an order of the United States District Court for the Southern District of New York, Lee P. Gagliardi, *Judge,* [1979-2] Trade Cas. (CCH) ¶ 62,758 (1979), granting summary judgment dismissing complaint seeking injunctive and declaratory relief under the Sherman Act, 15 U.S.C. §§ 1 *et seq.*, and damages under state libel law.

Reversed and remanded.

DONALD WEST, New York, N.Y., *for Plaintiff-Appellant.*

ROBERT P. BORSODY, New York, N.Y. (Philip M. Berkowitz, Epstein Becker Borsody & Green, P.C., New York, N.Y., on the brief), *for Defendant-Appellee New York State Chiropractic Association.*

T. RICHARD KENNEDY, New York, N.Y. (George T. Vogel, Cabell, Kennedy, Hammer & French, New York, N.Y. on the brief), *for Defendant-Appellee Union Labor Life Insurance Company.*

SIDNEY S. ROSDEITCHER, New York N.Y. (Howard S. Veisz, Richard D. Friedman, Nancy A. Kilson, Paul, Seiss, Rifkind, Wharton & Garrison, New York, N.Y., on the brief), *for The Health Insurance Association of America as amicus curiae.*

Appendix A

KEARSE, *Circuit Judge:*

This appeal by plaintiff-appellant A. Alexander Pireno, a chiropractor, requires us to determine whether the exemption from the federal antitrust laws created for "the business of insurance" by § 2(b) of the McCarran-Ferguson Act (the "Act"), 15 U.S.C. § 1012(b) (1976), applies to an insurer's practice of submitting claims for chiropractic services to a peer review committee, composed of chiropractors, which opines whether the services rendered and fees charged are "usual," "reasonable," "customary," or the like, within the meaning of the insurance policy. The district court held that the peer review practice instituted by defendant-appellee New York State Chiropractic Association ("NYSCA"), and availed of by defendant-appellee Union Labor Life Insurance Company ("ULL"), was exempt from antitrust scrutiny under § 2(b), and therefore granted summary judgment dismissing Pireno's complaint for injunctive and declaratory relief under the federal antitrust laws and for damages under state libel law. [1979-2] Trade Cas. (CCH) ¶ 62,758 (S.D.N.Y. 1979). Our own reading of § 2(b) in light of the Supreme Court's decision in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) *("Royal Drug")*, persuades us that the § 2(b) exemption does not shield the peer review procedure from examination under the antitrust laws. Accordingly, we reverse the order and remand the matter for further proceedings.

I. FACTS AND PRIOR PROCEEDINGS

This case arises from the efforts of the chiropractic profession to obtain for its practitioners and their patients the benefits of contemporary health insurance programs. Until the early 1970's, many health insurance

carriers excluded chiropractic services from coverage under their policies. Although New York amended its insurance laws in 1971 to require health insurance carriers to pay certain claims for services performed by a chiropractor, *see* N.Y. Ins. Law § 221-5(e) (McKinney Supp. 1980-1981), carriers and their medical advisors were frequently unfamiliar with chiropractic, and they therefore found it difficult to determine whether the services rendered and fees charged to insurance claimants were "usual," "customary," and "reasonable" within the limitations of typical health insurance policies. Responding to this situation, which adversely affected the chiropractors' livelihood and their patients' ability to obtain needed services, NYSCA, a nonprofit New York corporation, established a peer review committee in 1971.

The peer review committee, comprised of ten New York chiropractors, was intended primarily to aid insurers in evaluating claims for chiropractic services. Under the procedures it eventually adopted, the committee renders an opinion on the reasonableness of a chiropractor's treatment and charges in a given case at the request of the insurer; the assessment of the treatment is based on information concerning the patient supplied by the insurance carrier and the treating chiropractor, while the assessment of fees takes into account a variety of factors, including the amount and type of care provided, the condition and history of the patient, and the location and training of the treating chiropractor. Opinions of the committee are not binding unless the parties agree beforehand that they will be. Although the committee's review procedure is used primarily by insurers, it is also available to patients, governmental agencies, and chiropractors themselves. In addition to reviewing claims, the commit-

tee serves to some extent as a monitor of professional ethics and as a public relations organ.

ULL, a Maryland insurer doing business in New York, has been using the committee's claims review procedure since January 1973. ULL issues several types of policies that cover chiropractic services, all or most of which contain some sort of "reasonableness" limitation on the coverage provided. For example, its "major medical" and "basic" health care policies limit coverage to "reasonable charges for necessary medical care and services," and its "supplemental accident expenses" plan limits coverage to charges "not in excess of the regular and customary charges for the services and treatment furnished." When ULL determines that a particular claim is substantially above past chiropractic claims it has received for similar services, it refers the matter to the committee for review in accordance with the procedures described above. Although ULL apparently has never entered into an agreement with a claimant whereby it would accept the committee's determination as binding, plaintiff contends that ULL undeviatingly abides by such determinations.

Pireno has been the subject of peer review proceedings on a number of occasions.[1] The defendants assert that Pireno treats his patients in a manner calculated to maximize the number of treatments for a particular condition, and that his fees for these treatments are unusually high. For his part, Pireno contends that the committee members, who are not named as defendants in this action, practice "antiquated" techniques that they seek to impose on their more innovative competitors. The

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1 Plaintiff and defendant NYSCA dispute the number of times plaintiff's patients' claims have been referred to the peer review committee, plaintiff asserting that there were over forty referrals, defendant contending that there were only twelve.

dispute between Pireno and NYSCA culminated in the filing of the present lawsuit by Pireno in September 1976.[2]

In his complaint, Pireno alleged that ULL, NYSCA, and other unidentified persons had combined to restrain trade in chiropractic services in violation of § 1 of the Sherman Act, 15 U.S.C. § 1 (1976). Specifically, Pireno alleged that NYSCA and ULL conspired to employ the peer review committee and its claims review procedure as a means of fixing prices for chiropractic services. Plaintiff sought declaratory and injunctive relief against the alleged conspiracy. In addition, he asserted that NYSCA had libeled him by sending copies of the committee's opinion letters concerning his charges and methods of practice to his patients.[3] He sought $1 million in damages for the alleged defamations.

After extensive discovery, NYSCA and ULL moved for summary judgment dismissing the complaint. The motions were granted on the ground that the defendants' actions were exempt from the antitrust laws by virtue of § 2(b) of the McCarran-Ferguson Act. While recognizing

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2 Plaintiff Pireno apparently became an enthusiastic supporter of peer review shortly after NYSCA instituted the procedure in 1971. At the time, Pireno was engaged in a running dispute with ULL concerning its former practice of sending claims substantiation forms to the treating chiropractor in connection with most of its insureds' claims for chiropractic services; Pireno sought to charge ULL a $25.00 fee for completing each form, and ULL refused to pay. Pireno then adopted a policy of requesting peer review whenever ULL asked him to substantiate a claim. Subsequently, however, ULL began on its own initiative to submit Pireno's patients' claims to the peer review committee, and on several occasions the committee disapproved the claim. As Pireno puts it, these experiences with the peer review committee persuaded him that he "was dealing with the enemy rather than with allies." This litigation ensued.

3 Defendants contend that the committee never sent copies of its opinion letters to plaintiff's patients.

that the Supreme Court's decision in *Royal Drug, supra,* had narrowed the § 2(b) exemption for the "business of insurance" to such core insurance functions as the underwriting and spreading of risk, the district court held that the defendants used the peer review procedure for underwriting and risk-spreading purposes, and that the procedure therefore constituted the "business of insurance." In addition, the court held that the procedure was sufficiently regulated by state law to come within the § 2(b) exemption, and that Pireno had failed to produce sufficient evidence that the procedure entailed a "boycott, coercion or intimidation" subject to the antitrust laws under § 3(b) of the McCarran-Ferguson Act, 15 U.S.C., § 1013(b). Finding the defendants' antitrust immunity therefore complete, the court dismissed Pireno's Sherman Act claim, and declined to retain jurisdiction over his state law libel claim.[4]

On appeal, Pireno contends that the defendants' use of the peer review procedure is not entitled to antitrust immunity, arguing principally that peer review is not the "business of insurance" within the Supreme Court's interpretation of that phrase in *Royal Drug, supra.* We

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[4] In his complaint, Pireno had also named as a defendant the International Chiropractors Association ("ICA"). The district court's grant of summary judgment dismissing the complaint as to NYSCA and ULL did not deal with ICA, and the judgment entered on that decision on March 20, 1979, was not then final and appealable under 28 U.S.C. § 1291 (1976). Pireno nonetheless filed a notice of appeal on April 18, 1979. Thereafter, the action was dismissed with prejudice as to ICA, pursuant to a stipulation "so ordered" by the district court on June 11, 1979. The premature notice of appeal did not deprive the district court of jurisdiction to enter such an order, *Leonhard v. United States,* 633 F.2d 599, 609-10 (2d Cir. 1980), and the June 11 order ended the case with respect to the only remaining defendant. Hence, we treat the March 20, 1979, judgment as having become final and appealable on June 11, 1979, *see Jetco Electronic Indus. Inc. v. Gardiner,* 473 F.2d 1228, 1231 (5th Cir. 1973), and treat Pireno's early notice of appeal as having been timely filed thereafter.

agree, and we reverse the order of the district court and remand the action for further proceedings.[5]

II. DISCUSSION

A. *McCarran-Ferguson and Royal Drug*

Enacted in response to the Supreme Court's decision in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), which overturned settled precedent by holding that the writing of insurance was "commerce" subject to federal regulation under the Commerce Clause of the Constitution,[6] the McCarran-Ferguson Act expresses a strong federal policy favoring state regulation of

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[5] In view of our disposition of the "business of insurance" issue, we need not decide whether New York has regulated the peer review process to such an extent as to satisfy the "state regulation" requirement of the McCarran-Ferguson antitrust defense. We observe, however, that defendant NYSCA itself does not appear to be regulated by state law in the manner § 2(b) requires. Although N.Y. Ins. Law § 271 (McKinney 1966) brings "corporation[s] . . . engaged in the business of insurance" within the jurisdiction of state insurance authorities, the statute was fairly clearly drafted with the focus on corporations in the insurance industry. The fact that NYSCA is a corporation that advises an insurer as to the reasonableness of chiropractic fees makes it no more a member of the insurance industry than would be a financial consultant who advises an insurer on the prudent investment of its reserves.

[6] The assumption that insurance transactions were not "commerce" can be traced to *Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 183 (1868), in which the Court held that a state statute which regulated foreign insurers was not invalid under the Commerce Clause because "issuing a policy of insurance is not a transaction of commerce." Subsequent cases repeated and broadened this statement. *See United States v. South-Eastern Underwriters Ass'n, supra*, 322 U.S. at 543-44 & n.18. In *South-Eastern Underwriters*, a criminal prosecution for violations of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, the court reversed direction and rejected the argument that Congress had no power to regulate the insurance practices alleged in the indictment, holding that "the business of insurance" was indeed "commerce" subject to federal regulation. 322 U.S. at 539-53.

the insurance industry. In § 1 of the Act, Congress declared "that the continued regulation and taxation by the several States of the business of insurance is in the public interest." 15 U.S.C. § 1011 (1976). Section 2 provides in part as follows:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .

Id. §§ 1012(a), (b). The statute thus preserves broad state authority to regulate "the business of insurance," and provides a broad immunity from federal regulation not specifically directed to the insurance business.

The McCarran-Ferguson Act also contains one important exception to the general rule of immunity from federal regulation, for it expressly provides only a limited immunity from the federal antitrust law.[7] Thus § 2(b) states the proviso that the principal federal antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by State law." *Id.* § 1012(b). In addition, under section 3(b) of McCarran-Ferguson, the Sherman Act remains applicable to "any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation," *id.* § 1013(b), even

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[7] The McCarran-Ferguson Act also specifies that certain federal labor laws remain applicable to the business of insurance. 15 U.S.C. § 1014.

if the activity in question would otherwise be exempt from the antitrust laws by virtue of § 2(b). Thus, as the district court observed, the McCarran-Ferguson immunity to antitrust claims has three prerequisites: (1) the challenged conduct must constitute the "business of insurance"; (2) the conduct must be regulated by state law; and (3) it must not take the form of boycott, coercion, or intimidation. [1979-2] Trade Cas. (CCH) ¶ 62,758, at 78,376.

In *Royal Drug, supra,* the Supreme Court sharply restricted the availability of this antitrust exemption by placing a narrow construction on the statutory concept of the "business of insurance." The case involved an antitrust challenge to certain agreements between Blue Shield of Texas, a health insurer, and several pharmacies; the agreements obligated contracting pharmacies to provide prescription drugs to Blue Shield's insureds at a fixed markup of $2.00 per prescription.[8] The plaintiffs, independent pharmacies that had not entered into such provider contracts with Blue Shield, alleged that the contracts were agreements to fix the prices of drugs and constituted a group boycott of nonparticipating pharmacists, in violation of § 1 of the Sherman Act. The defendants, Blue Shield and some of its participating pharma-

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[8] Under Blue Shield's provider contracts, participating pharmacies were required to supply prescription drugs to Blue Shield's insureds for a fixed fee of $2.00 per prescription; the pharmacy was then able to recover directly from Blue Shield the cost of obtaining the drug. If the insured chose a pharmacy that had not entered into a provider contract with Blue Shield, he was obligated to pay the full price for the prescription, and could then recover from the insurer 75% of the difference between that price and $2.00. As the *Royal Drug* Court noted, the terms of the provider contracts were such that only pharmacies whose distribution costs were less than $2.00 could profitably participate in the plan, *see* 440 U.S. at 209, and the terms of Blue Shield's insurance policies would naturally encourage its insureds to patronize only participating pharmacies.

cies, contended that the provider contracts constituted the "business of insurance" and that the other requirements of the McCarran-Ferguson exemption were met. Overturning what was then the prevailing view among the courts of appeals,[9] and adopting a narrower reading of the statutory language than had been suggested by its own prior decisions, *see* Note, *The Definition of "Business of Insurance" Under the McCarran-Ferguson Act After Royal Drug*, 80 Colum. L. Rev. 1475, 1479-81 (1980), the Court held that the disputed provider agreements were not "the business of insurance," and that the defendants' practices were therefore not immune from antitrust scrutiny.

In reaching this conclusion, the Court began with the premise that the McCarran-Ferguson antitrust exemption "is for the 'business of insurance,' not the 'business of insurers.' " 440 U.S. at 211. *See also SEC v. National Securities, Inc.*, 393 U.S. 453, 459-60 (1969). It therefore considered whether the disputed provider contracts bore the essential characteristics of insurance, which the Court characterized as "the spreading and underwriting of a policy holder's risk," *Royal Drug, supra*, 440 U.S. at 211. The Court noted that the provider contracts did not spread the risks insured against, but were "merely arrangements for the purchase of goods and services" that reduced the insurer's cost of meeting its obligations to its insureds. *Id.* at 214; *see id.* at 213-15. In addition, while

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9 The Supreme Court cited the decision of the Fifth Circuit in *Royal Drug*, 556 F.2d 1375 (1977), which it affirmed, as being "in conflict with" the decisions of the courts of appeals in *Frankford Hospital v. Blue Cross*, 554 F.2d 1253 (3d Cir.) (per curiam), *cert. denied*, 434 U.S. 860 (1977); *Anderson v. Medical Service*, 551 F.2d 304 (4th Cir. 1977) (mem.); and *Proctor v. State Farm Mutual Automobile Ins. Co.*, 561 F.2d 262 (D.C. Cir. 1977), *vacated and remanded mem.*, 440 U.S. 942 (1979). *See* 440 U.S. at 208-09 n.2.

noting that its decision in *SEC v. National Securities, Inc., supra,* had stressed protection of an insurer's reliability as an aspect of "the business of insurance," the Court rejected the argument that the provider contracts so closely affected Blue Shield's reliability as to constitute the "business of insurance," reiterating that the contracts were merely cost-cutting devices. *Royal Drug, supra,* 440 U.S. at 215-17. Thus, the Court concluded that the provider agreements did not bear any of the essential characteristics of insurance, and so could not constitute "the business of insurance."

The Court found additional support for its conclusion in the history and purpose of the McCarran-Ferguson Act. The Court noted that, although the legislation initially proposed would have completely exempted the insurance industry from the antitrust laws, *id.* at 218-19, the statute as enacted was designed to provide "only a limited exemption from the antitrust laws," *id.* at 218 n.18. Quite apart from preserving state authority to tax and regulate the insurance industry, Congress had generally intended that the antitrust laws apply to insurers' activities, save as to certain core activities—"the business of insurance"—when regulated by state law.[10] *Id.* at 219-20. These core activities were intended to include the transfer and spreading of risk, but not mere cost-cutting devices:

> References to the meaning of the "business of insurance" in the legislative history of the McCarran-Ferguson Act strongly suggest that Congress under-

[10] The structure of the statute supports this analysis. Section 2(b) provides that the antitrust laws "*shall be applicable* to the business of insurance" to the extent that it is unregulated by state law. (Emphasis added.) Of course, the antitrust laws apply to activities that are not "the business of insurance," regardless of state regulation.

> stood the business of insurance to be the underwriting and spreading of risk. Thus, one of the early House Reports stated: "The theory of insurance is the distribution of risk according to hazard, experience, and the laws of averages. These factors are not within the control of insuring companies in the sense that the producer or manufacturer may control cost factors." H.R. Rep. No. 873, 78th Cong. 1st Sess. 8-9 (1943).

Id. at 220-21 (footnote omitted). Thus, while an insurance company obviously would not long remain viable if it continually incurred exorbitant expenses, this phenomenon is hardly unique to insurers qua insurers, and *Royal Drug* therefore clearly indicates that mere cost-cutting devices are not the "business of insurance":

> If agreements between an insurer and retail pharmacists are the 'business of insurance' because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control—whether with automobile body repair shops or landlords.[40]

40 There is no principled basis upon which a line could rationally be drawn that would extend the McCarran-Ferguson Act exemption only to an insurer's agreement with providers of goods and services to be furnished to its policy holders—such as agreements with hospitals, doctors, lawyers, and the like. But assuming that such a line could rationally be drawn, to hold that even such provider agreements are the "business of insurance" is to ignore the language and purpose of the Act not to exempt the insurance industry as such from the antitrust laws.

Id. at 232. Finally, the Court's review of the legislative history indicated that Congress had adopted the antitrust exemption primarily to accommodate the industry's need for cooperative ratemaking, an activity involving only

insurers inter se and distinctly different from the purchase of goods and services from noninsurers pursuant to the challenged provider contracts. *Id.* at 220-24.

Thus, under *Royal Drug*, the McCarran-Ferguson antitrust exemption for "the business of insurance" is to be strictly limited to only the quintessential insurance functions. With this background in mind, we consider whether the peer review procedure challenged here constitutes "the business of insurance."

B. *Peer Review and the "Business of Insurance"*

We begin with *Royal Drug*'s basic premise that "the underwriting or spreading of risk is a critical determinant in identifying insurance." 440 U.S. at 213; *id.* at 211. This being so, an activity or procedure that does not either transfer risk from insured to insurer or spread the risk among insureds is not the business of insurance. We find neither risk transference nor risk spreading in the peer review process.

Peer review is plainly not a form of risk-spreading. That concept, as used in *Royal Drug*, refers to the fact that insurance disperses the risk of loss that will be suffered upon the occurrence of a particular event over a large number of policyholders, not all of whom will actually experience the event, so that each policyholder can purchase protection against the loss for a premium amount substantially smaller than the loss he would sustain if the event were to occur to him. *See* 440 U.S. at 211, citing 1 G. Couch, Cyclopedia of Insurance Law § 1:3 (2d ed. 1959). *See also* Note, *supra*, 80 Colum L. Rev. at 1478. Peer review has no role in the spreading of risk in this fashion. Nor does it transfer risk. The risk that an insured will require chiropractic treatment has been transferred from the insured to the insurer by the

very purchase of insurance. Peer review takes place only after the risk has been transferred by means of the policy, and then it functions only to determine whether the risk of the entire loss (the insured's cost of treatment) has been transferred to the insurer—that is, whether the insured's loss falls within the policy limits. Peer review is thus not a means of transferring risk from insured to insurer. At most, it is an aid in determining the scope of the transfer after it has been made.

The district court held, and defendants here urge, that peer review does transfer risk because it determines "the extent to which an individual insured must bear the full cost of chiropractic services, or instead have that cost borne by the insurer." [1979-2] Trade Cas. (CCH) ¶ 62,758, at 78,377. With due respect to the district court, we believe this argument fails. To the extent that a policyholder must bear the cost of a particular loss, he has obviously retained the risk of that loss, and has not transferred it to his insurer. *Cf. SEC v. Variable Annuity Life Insurance Co.*, 359 U.S. 65 (1959). Thus, the fact that a policyholder may be required to bear part or all of the cost of chiropractic services as a result of peer review does not mean that peer review transfers risk in the sense contemplated by *Royal Drug*. On the contrary, peer review merely measures the extent to which a policyholder has failed to effect such a transfer.

Viewed from this perspective, peer review is simply a form of cost reduction. By enabling an insurer to judge more precisely whether a chiropractor's fees and course of treatment are "reasonable," "usual," or the like, peer review inevitably permits the insurer to minimize its costs. First, it reduces the likelihood that an insurer will mistakenly pay a claim for charges or treatments that fall outside the policy limits. Second, and more fundamen-

tally, the more precise enforcement of these policy limitations made possible by peer review enables the insurer more effectively to prevent, or at least diminish, increases in the cost of the chiropractic services that it has agreed to indemnify:

> A policy that pays only the "usual" charges for a service will induce policyholders to avoid patronizing more expensive providers. To the extent that a significant portion of the population holds such policies, prices for the services in question will tend to remain at the current "usual" level; increases that might otherwise occur will be hampered. This stabilization of prices in the community will in turn be reflected in the insurer's own costs.

Note, *supra*, 80 Colum. L. Rev. at 1487.[11] Thus peer review, like the provider contracts at issue in *Royal Drug*, "serve[s] only to minimize the costs [the insurer] incurs in fulfilling its underwriting obligations." 440 U.S. at 213 (footnote omitted). Because peer review, like the provider contracts, does not transfer or spread risk but merely cuts

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[11] Peer review may offset this effect on prices to some extent, for committee members' self-interest may cause them to set the "usual" rate above prices that would otherwise obtain in the market. Nonetheless, the inevitable effect of peer review would seem to be stabilization of prices and mitigation of future price increases, provided that insurers actually follow the committee's recommendations.

The commentator quoted in the text accompanying this footnote argues that a policy limiting coverage to "usual," "customary," or "reasonable" charges itself falls outside "the business of insurance," regardless of whether peer review is used to enforce these policy limits. Note, *supra*, 80 Colum. L. Rev. at 1487-88. The status of defendant ULL's policies is not before us, and we of course express no views upon the subject. We note in passing, however, that the specification of the terms of the contract between insurer and insured seems far more closely associated with the business of insurance than does the use of consultants in interpreting the policy limits.

costs, it is not "the business of insurance" within the meaning of the McCarran-Ferguson Act.

This analysis largely answers the defendants' other principal arguments. Relying on the Supreme Court's statements that "the core of the 'business of insurance' " concerns such matters as "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement," *Royal Drug, supra,* 440 U.S. at 215-16, quoting *SEC v. National Securities, Inc., supra,* 393 U.S. at 460, defendants argue that peer review constitutes "the business of insurance" because the peer review committee mediates disputes between insurer and insured, interprets the policy limitations, and performs functions similar to those of an insurance adjuster. We think, however, that *Royal Drug* sets forth a substantially narrower scope for the "business of insurance" exemption than its approving citation of *National Securities* might suggest.[12] *National Securities* involved the relationship between an insurance company and its stockholders, not the relationship between insurer and insured. Thus the *National Securities* Court's observation that the business of insurance primarily concerns the latter relationship sought merely to exclude the "markedly different" relationship of insurer to stockholder, 393 U.S. at 460, and it certainly did not indicate

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12 One commentator has suggested that the phrase "the business of insurance" may have a broader meaning in those provisions of the McCarran-Ferguson Act that preserve state insurance laws from federal preemption than it does in the § 2(b) antitrust exemption, and that this duality of meaning explains the apparent inconsistency of *Royal Drug,* which interpreted the § 2(b) exemption, with earlier cases that interpreted the other provisions. *See* Note, *supra,* 80 Colum. L. Rev. at 1481-84. We have no occasion to pass upon this theory in the present appeal, but note that statutory language may sometimes be more fluid than the well-known "rule of consistency" in statutory interpretation might suggest.

that all facets of the relationship between insurer and insured are the business of insurance. Indeed, *Royal Drug* makes clear that some are not, since it held *not* the "business of insurance" provider contracts whose effect was to require any insured who selected a nonparticipating pharmacy to pay more for drugs than if he had selected a participating pharmacy. (*See* note 8 *supra.*) Here, an insured who consults an unreasonably expensive chiropractor will be required to pay more if he had consulted one whose charges were "reasonable." We see no meaningful difference between the effects on the insurer-insured relationship in *Royal Drug* and in the present case.

Moreover, although it is true that the peer review committee performs an "adjusting" function commonly performed by insurance industry personnel, that fact alone cannot convert peer review into "the business of insurance." First, it is by no means clear that claim-settlement itself constitutes "the business of insurance" within the meaning of the antitrust exemption as interpreted in *Royal Drug. See* Note, *supra,* 80 Colum. L. Rev. at 1487. Second, it remains true that the peer review committee is not a member of the insurance industry, and that the antitrust exemption seeks primarily to shield agreements among insurers, not those between insurers and persons outside the industry. *See Royal Drug, supra,* 440 U.S. at 221-22, 224-25 n.32. Thus we conclude that the resemblance of peer review to intraindustry claims adjusting does not warrant a departure from the analysis compelled by *Royal Drug.*[13]

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13 We adhere to this conclusion even though the Fourth Circuit recently reached a contrary result in a factually identical case, *Bartholomew v. Virginia Chiropractors Ass'n, Inc.,* 612 F.2d 812 (4th Cir. 1979), *cert. denied,* 446 U.S. 938 (1980). Defendants argue that because the

In sum, we hold that peer review is not "the business of insurance" within the meaning of § 2(b) of the McCarran-Ferguson Act, and that defendants' use of the procedure is therefore not immune from scrutiny under the antitrust laws. Accordingly, we reverse the order of the district court dismissing the complaint, and remand for further proceedings.[14]

Supreme Court declined to grant certiorari in *Bartholomew* even though it was the first significant post-*Royal Drug* decision by a court of appeals, and because the facts of the case were identical to those presented here, the decision is "more than just precedent" and that it carries a weight "approaching a collateral estoppel or a *res judicata* effect." We cannot agree. The denial of certiorari has no precedential significance, *see generally* Linzer, *The Meaning of Certiorari Denials*, 79 Colum. L. Rev. 1227 (1979), and defendants have not asserted that Pireno was a party to, or was in any way represented in, the *Bartholomew* litigation. Accordingly, *Bartholomew* has no preclusive effect upon Pireno, and it has no more precedential force than any other decision of one of our sister circuits. It is persuasive authority, but we remain free to disagree with it, and we do so disagree.

14 We decline the defendants' invitation to affirm the order on the basis of the other defenses raised in their answers to plaintiff's complaint. These are matters better addressed to the district court in the first instance, *see Dandridge v. Williams*, 397 U.S. 471, 475-76 n.6 (1970), and our disposition of this appeal expresses no opinion as to the merits of plaintif's claims.

APPENDIX B

Opinion of the United States District Court

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

76 Civ. 4309

A. ALEXANDER PIRENO,

Plaintiff,

—against—

NEW YORK STATE CHIROPRATIC ASSOCIATION, UNION LABOR LIFE INSURANCE COMPANY and INTERNATIONAL CHIROPRACTORS ASSOCIATION,

Defendants.

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GAGLIARDI, D.J.

Plaintiff A. Alexander Pireno, a licensed New York chiropractor, has commenced this action for injunctive and declaratory relief under the federal antitrust laws and for damages under state libel law. No jurisdictional basis is alleged in the complaint, but jurisdiction lies pursuant to 28 U.S.C. §1337 and principles of pendent jurisdiction. At issue in this case is the defendants' "peer review" system, by which a committee of licensed chiropractors are utilized to review the "reasonablenesss" of claims submitted by insureds to their insurance company under policies providing for chiropractic coverage. Plaintiff alleges that through the peer review process the defendant Union Labor Life Insurance Company ("ULL") has conspired with the New York State Chiropractic Association ("NYSCA") and the International Chiropractors Association to fix the prices plaintiff charges for his professional services in

violation of §1 of the Sherman Act, 15 U.S.C. §1. ULL and NYSCA have moved for summary judgment dismissing the complaint pursuant to Rule 56, Fed. R. Civ. P. For the reasons stated below, the motion is granted.

Statement of Facts

Defendant NYSCA, a New York not-for-profit corporation, is a professional association whose membership consists solely of licensed New York chiropractors. In the early 1970's the NYSCA became concerned about the reluctance of many health insurance companies to provide coverage for chiropractic services. Moreover, those companies that did provide such coverage disallowed many of the claims submitted to them on the advice of the doctors of medicine whom they employed to evaluate claims and who were skeptical of chiropractic services. In an effort to increase the number of insurance companies providing chiropractic coverage in their health policies and to reduce the number of claims denied by those companies providing coverage, the NYSCA, in 1971, established a Peer Review Committee (the "Committee"). NYSCA thereafter offered the Committee's claims review services to various insurance companies, including defendant ULL. In January, 1973, ULL accepted NYSCA's offer and proceeded to submit claims for chiropractic services submitted by its insureds for the Committee's review. The Committee performs this service without charge.

ULL is a licensed Maryland insurer which does business in New York. New York requires insurers like ULL to reimburse insureds for chiropractic treatment whenever a policy "provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed

chiropractor." New York Ins. Law §221(5)(e) (McKinney Cum. Supp. 1978-79). ULL issues several different policies in which the coverage includes chiropractic services. Most of the plaintiff's patients who have submitted claims to ULL have been members of groups who had selected "basic" and "major medical" coverages for non-occupational sickness or accidental bodily injury. These policies provide that coverage is limited, *inter alia*, to "reasonable charges for necessary medical care and services." Other patients of plaintiff have had "supplemental accident expenses" coverage with ULL, providing reimbursement for charges for treatment of non-occupational, accidental bodily injuries. This coverage is limited to charges "not in excess of the regular and customary charges for the services and treatment furnished." In all instances, coverage is limited to those services lawfully within the scope of a chiropractor's services.[1] When ULL decides not to pay all or part of a claim for chiropractic services because it believes that the charges are not "reasonable" or are "in excess of the regular and customary" amount, it submits the claim to the Committee for its evaluation.[2]

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[1] In New York, a license to practice chiropractic is generally limited to the correction "by manual or mechanical means structural balance, distortion, or subluxation in the human body for the purpose of removing nerve interference", Education Law §6551(1), (McKinney 1972), and a chiropractor may not prescribe or administer drugs or use diagnostic or therapeutic methods involving biological means. *Id.* §6551(3).

[2] The request for peer review almost always comes from the insurer although, on occasion, chiropractors and their patients have requested peer review if the insurer has denied or reduced a claim and it is hoped that favorable review from the Committee might convince the insurer that the claim is reasonable. Thus, plaintiff has requested peer review of ULL's denials of his patients' claims on several occasions.

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Upon receipt of a request for review, the Committee sends a questionnaire form to the treating chiropractor. In addition to providing the information asked for in the questionnaire, the chiropractor will often provide additional documentation, including x-rays, to substantiate his patient's claim. The Committee's Procedural Guidelines provide that in formulating its opinions as to the "reasonableness" of a treating chiropractor's charges, the Committee must take into consideration the following factors: the practitioner's experience and specialty degrees; the location of his office; the number of visits and amount of time spent with the patient; the patient's age, occupation, general physical condition and history of prior treatment; and x-ray findings. The Committee, however, does not undertake its own examination of the insured patient. A Committee opinion letter generally contains only information as to whether the number of visits and the fee charged for the services performed is "usual, reasonable and customary." The defendants claim that Committee opinions, once rendered, are disclosed only to the party requesting review, generally the insurer, and the treating chiropractor. Plaintiff, however, contends that insured patients also receive copies of Committee opinions.

The Committee's Procedural Guidelines provide that Committee opinions are not binding upon any of the parties involved unless they so agree and advise the Committee in writing prior to the commencement of review. Thus, after the Committee renders its opinion the insurer remains free to reject it and make its own determination of its liability under its policy. Moreover, absent his consent to a binding determination, the patient remains free to contest the insurer's evaluation of the "reasonableness" of his claim and may bring suit to enforce the terms of his

policy. Similarly, if the treating chiropractor accepts an assignment of contractual rights from his patient he may sue the insurer to recover on the policy. If the chiropractor does not accept such an assignment, of course, the patient is obligated to pay the chiropractor's entire fee notwithstanding the refusal of the insurer to pay all or part of the claim. Plaintiff contends, however, that ULL has generally regarded Committee opinions as "binding" even when the parties have not consented to such an arrangement.

Plaintiff has been engaged in the practice of chiropractic medicine in the New York City area since 1960. He claims that over forty of his patients have had their claims reviewed by the Committee; NYSCA contends that only twelve claims submitted by plaintiff's patients have been the subject of peer review of which only four involved defendant ULL. Plaintiff never accepts an assignment from a patient whereby he agrees to accept insurance proceeds as *full* payment of his bill; on rare instances he has accepted assignments of proceeds as partial payment of his fee while reserving the right to proceed against the patient for the remainder. Rather, plaintiff's usual practice is to request, and receive, payment from the patient at the time services are rendered. Plaintiff has never been involved in a peer review determination to which the parties agreed to be bound as provided in the Committee's Procedural Guidelines. Thus, whatever effect the Committee's opinion may have on ULL's decision to pay an insured's claim, plaintiff has usually received his full fee in advance. While the defendants contend that plaintiff's fees for chiropractic services are among the highest in the profession, plaintiff denies that his fees are any higher than other practitioners similarly situated.

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Plaintiff alleges that the defendant's actions constitute a conspiracy to fix the prices plaintiff charges for his services in violation of §1 of the Sherman Act. The alleged effects of the conspiracy have been: 1. to deprive plaintiff's patients of both the benefits of free competition in the acquisition of his services and the coverage to which they are entitled from ULL under the terms of their policies; and 2. to restrain plaintiff in his ability to make his chiropractic services available to the public. Plaintiff seeks declaratory and injunctive relief against the practice of peer review. Plaintiff also alleges that opinion letters issued by the Committee to plaintiff's patients have libeled him in the practice of his profession for which he seeks $1,000,000 in punitive damages.[3]

DISCUSSION

A. *The Sherman Act Claim*

Defendants NYSCA and ULL have moved for summary judgment dismissing plaintiff's antitrust claim on several grounds. The principal defense raised by these defendants to this claim is the statutoy exemption contained in the McCarran-Ferguson Act, 15 U.S.C. §§1011-1015. For the

[3] Rule 10(b), Fed. R. Civ. P., requires that the contents of each alleged claim be limited as far as practicable to a statement of a single set of circumstances and that each claim founded upon a separate transaction be stated in a separate count whenever separation facilitates the clear presentation of the matters set forth. In apparent disregard of this rule, the complaint amalgamates in a single count the federal antitrust claim and the state law defamation claim. Since the parties have treated the complaint as attempting to state two separate causes of action, the court will do so as well.

reasons stated below, the court concludes that the defendants are exempt under this statute and plaintiff's Sherman Act claim must be dismissed.

The legislative history of the McCarran-Ferguson Act has been canvassed at length in two recent Supreme Court decisions, *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 47 U.S.L.W. 4203 (February 27, 1979) ("*Royal Drug*") and *St. Paul Fire & Marine Insurance Co.* v. *Barry*, 98 S. Ct. 2923 (1978). The law was enacted in 1945 in response to the Supreme Court's decision in *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944), which held, contrary to well-established precedent, that the insurance industry was part of interstate commerce subject to Congressional regulation under the commerce clause and, moreover, that Congress did not intend to exempt the business of insurance from the operation of the Sherman Act. *Royal Drug, supra*, 47 U.S.L.W. at 4206; *Barry, supra*, 98 S. Ct. at 2928-29. Although Congress' primary concern in the wake of that decision was to ensure that the States would continue to be empowered to regulate the business of insurance, an additional concern was the applicability of the antitrust laws to the industry. Instead of a total exemption, Congress provided that the federal antitrust laws are applicable "to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. §1012(b). Moreover, the Sherman Act remains applicable "to any agreement to boycott, coerce, or intimidate or act of boycott, coercion or intimidation." 15 U.S.C. §1013(b). Thus, there are three distinct elements to the Act's limited antitrust exexemption: 1. the challenged practices must constitute the "business of insurance"; 2. they must be regulated by state law; and 3. they must not take the form of "boycott, coer-

cion or intimidation." *Royal Drug, supra,* 47 U.S.L.W. at 4216 (dissenting opinion); 7 Von Kalinkowski, *Antitrust Laws & Trade Regulation* §§47.01-.03 (1978 ed).

1. *The Business of Insurance*

McCarran-Ferguson does not exempt, the business of insurance companies from the antitrust laws; it exempts only the "business of insurance." *Royal Drug, supra,* 47 U.S.L.W. at 4207 n. 18. In creating the exemption, "Congress was concerned with the type of state regulation that centers around the contract of insurance . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.'" *SEC* v. *National Securities Inc.,* 393 U.S. 453, 460 (1969). "The primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." *Royal Drug, supra,* 47 U.S.L.W. at 4205. *Accord, SEC* v. *Variable Annuity Life Insurance Co.,* 359 U.S. 65, 73 (1959).

In support of their contention that their actions constitute the "business of insurance", the defendants have relied upon cases from several Courts of Appeals holding that "provider agreements" between insurance companies or health care organizations and the providers of health or other services are part of the "business of insurance" under the Act. *See, e.g., Proctor* v. *State Farm Mutual Automobile Insurance Co.,* 561 F.2d 262 (1977), *cert. pending,* No. 77-580; *Doctors, Inc.* v. *Blue Cross of Greater Philadelphia,* 557 F.2d 1001 (3d Cir. 1976); *Frankford Hospital* v. *Blue Cross of Greater Philadelphia,* 554 F.2d 1253 (3d Cir.), *cert. denied,* 434 U.S. 860 (1977); *An-*

derson v. *Medical Service of the District of Columbia*, 551 F.2d 304 (4th Cir. 1977); *Travelers Insurance Co.* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973). These cases hold that the close nexus between the cost of reimbursing insureds on their claims and the rates the insurer must charge necessarily brings agreements reducing the cost of providing covered services within the scope of the exemption. The Supreme Court's recent decision in *Royal Drug* effectively overrules this substantial body of precedent. The Court reasoned that the contracts that Blue Shield entered into with providers of pharmaceutical services were unrelated to the underwriting or spreading of risk among its insureds and were merely arrangements enabling Blue Shield to purchase goods and services, and thereby fulfill its underwriting obligations, at reduced cost.

> The benefit promised to Blue Shield policyholders is that their premiums will cover the cost of prescription drugs except for a $2 charge for each prescription. So long as that promise is kept, policyholders are basically unconcerned with arrangements made between Blue Shield and participating pharmacies.

47 U.S.L.W. at 4205.

In the instant case, by contrast, ULL's insureds are intimately and directly concerned with the peer review arrangement between ULL and the NYSCA's Committee. Unlike the agreement between Blue Shield and participating pharmacies, the peer review arrangement between ULL and the Committee serves to define the precise ex-

tent of ULL's contractual obligations to its insureds under their policies. Peer review may enable ULL to reduce its costs, but it does so through interpretation of the contractual relationship between insurer and insured. Determination of the rights of an insured under his policy is the "core of the business of insurance." *SEC* v. *National Securities, Inc., supra,* 393 U.S. at 460. Peer review, moreover, involves the spreading of risk, an indispensable element of the "business of insurance." *Royal Drug, supra,* 47 U.S.L.W. at 4206 n.12. The defendants determine the extent to which an individual insured must bear the full cost of chiropractic services, or instead have that cost borne by the insurer (and, through higher premiums, his fellow insureds). The Committee's role in evaluating claims submitted for review is thus akin to that played by the licensed adjuster, long an important figure in the settlement of claims against insurers.[4] *See* 16 J. Appleman

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[4] This court does not read *Royal Drug* to hold that any contractual arrangement between an insurer and a party other than an insured is outside the scope of the "business of insurance." Thus, the Supreme Court explicitly noted that Congress intended to make cooperative ratemaking efforts—horizontal agreements among insurers—exempt from the antitrust laws. 47 U.S.L.W. at 4207. Moreover, the Court stated that transactions between an insurer and its agents may also fall within the scope of the exemption. 47 U.S.L.W. at 4208 n.32. The Court distinguished insurer-agent agreements from the provider agreements at issue in *Royal Drug,* stating:

> Transactions between an insurer and an agent, unlike the Pharmacy Agreements, are wholly intra-industry; an insurance agent sells insurance while a pharmacy sells goods and services.

Id. In the case at bar, the Committee's sole function is peer review of submitted claims; it, too, functions solely within the industry of insurance.

& J. Appleman, *Insurance Law & Practice*, §§8646-50 (1968 ed.). The court thus concludes that ULL and the Committee are engaged in the "business of insurance."[5]

2. *Regulation by the State*

The second element of the McCarran-Ferguson exemption is that the challenged activity be "regulated by State law." 15 U.S.C. §1012(b). "[T]he state regulation which Congress provided should operate to displace . . . federal law means regulation by the State in which the [challenged activity] is practiced and has its impact." *FTC* v. *Travelers Health Ass'n.*, 362 U.S. 293, 299 (1960). The parties agree that New York—the state in which plaintiff's practice is located and most of his patients reside—is the applicable state jurisdiction.

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[5] A party need not be defined by state law as an insurance company to be engaged in the "business of insurance." Thus, in *Royal Drug*, the Supreme Court noted that at the time of the enactment of the McCarran-Ferguson Act most states did not consider health care organizations like Blue Shield to be engaged in the insurance business. 47 U.S.L.W. at 4208-09. The court stated, however,

> This is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the "business of insurance" within the meaning of the Act.

47 U.S.L.W. at 4210 n.37. *See also Lowe* v. *Aarco-American, Inc.*, 536 F.2d 1160, 1162 (7th Cir. 1976) (per curiam) (premium finance company engaged in "business of insurance"); *Manasen* v. *California Dental Services*, 424 F. Supp. 657, 662-66 (N.D. Cal. 1976) (prepaid health care plan engaged in "business of insurance").

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New York has enacted a pervasive scheme of regulation and supervision of insurance. Article IX-D of the Insurance Law prohibits any person[6] from engaging in any "unfair method of competition or unfair and deceptive act or practice in the business of insurance in accordance with the intent of Congress as expressed in [the McCarran-Ferguson Act]." *Id.* §270. Among the prohibited practices is the unfair settlement of claims. *Id.* §40-d, 273. The Superintendent of Insurance is empowered to issue cease and desist orders against such practices, *id.* §276, and may investigate, hold hearings and issue reports concerning unfair practices not specified elsewhere in Article IX-D. *Id.* §278. The practices complained of by plaintiff are clearly regulated by New York's insurance law. *See Dexter* v. *Equitable Life Insurance Society*, 527 F.2d 233, 236 (2d Cir. 1975).

Moreover, New York's own antitrust law proscribes the conduct alleged in the complaint. The Donnelly Act states that every contract, agreement or conspiracy whereby a monopoly is or may be established is illegal. New York General Bus. Law §340 (McKinney 1968). The Act was amended in 1948 and specifically made applicable to "licensed insurers . . . and other persons and organizations subject to the provisions of the insurance law." *Id.* §340 (2). On this basis too, the McCarran-Ferguson exemption operates as a bar to plaintiff's federal antitrust claim. *Steingart* v. *Equitable Life Assurance Society*, 366 F. Supp. 790, 793-94 (S.D.N.Y. 1973).

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[6] The statute defines "person" to mean "any individual, corporation, association, partnership . . . and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters." Ins. Law §271.

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3. *Boycott, Coercion or Intimidation*

Section 3(b) of the McCarran-Ferguson Act provides that the Sherman Act remains applicable "to any agreement to boycott, coerce or intimidate, or act of boycott, coercion or intimidation." 15 U.S.C. §1013(b). The complaint does not allege that the defendant's acts constitute "boycott, coercion, or intimidation." Nor do the facts alleged in the complaint fall within the scope of this exception. "The generic concept of boycott refers to a method of pressuring a party with whom one has a dispute by withholding, or enlisting others to withhold, patronage or services from the target." *St. Paul Fire & Marine Ins. Co.* v. *Barry, supra,* 98 S. Ct. at 2930. Plaintiff does not claim that the defendants have refused to deal with plaintiff's patients. It is not disputed that ULL continues to issue policies to plaintiff's patients and to reimburse them for plaintiff's charges to the extent that they are "reasonable" or "not in excess of the regular and customary charges." Nor does the complaint allege that the defendants have induced plaintiff's patients to refuse to patronize plaintiff. The complaint alleges only a conspiracy to fix prices and "price-fixing, in the absence of any additional enforcement activity, has [not] been treated either as a 'boycott' or 'coercion.'" *Id.* at 2932 n.18. *Accord, Proctor* v. *State Farm Mutual Auto Ins. Co., supra,* 561 F.2d at 274. Nor do plaintiff's affidavits in opposition to the motion for summary judgment make any factual showing on the issue of boycott. Rather, plaintiff conclusorily states that:

> When a patient is under treatment and submits a claim to his insurance carrier who in turn is told by the committee and repeats to the patient that

> the treatment he is receiving is excessive and unreasonable, he invariably stops treatment or questions the doctor's competence based upon the opinion of his "peers." . . . *While this plaintiff is in no position to demonstrate specifically which plaintiffs ceased treatment* because of these statements, since each of the patients who did so became alienated from the plaintiff as a result of the statements made about his professional competence, *he will clearly demonstrate at trial that this in fact, was the effect of the actions of the defendants.*

(Plaintiff's Affidavit in Opposition to NYSCA's Motion for Summary Judgment, p. 19) (emphasis added).

The question at this stage of the proceedings is whether plaintiff has come forward with sufficient evidentiary support for a claim of boycott—a claim not even raised in his complaint—to justify a trial on the merits. Plaintiff cannot preserve the issue of boycott for trial while sitting on his evidence concerning the defendant's inducement of his patients to refuse to deal with him. "A party opposing a motion for summary judgment simply cannot make a secret of his evidence until the trial, for in doing so he risks the possibility that there will be no trial." *Donnelly* v. *Guion*, 467 F.2d 290, 293 (2d Cir. 1972). *Accord, United States* v. *Pent-R-Books, Inc.*, 538 F.2d 519, 529 (2d Cir. 1976); *Applegate* v. *Top Associates, Inc.*, 425 F.2d 92, 96 (2d Cir. 1970); *Dressler* v. *MV Sandpiper*, 331 F.2d 130, 132-33 (2d Cir. 1964). Rule 56(e), Fed. R. Civ. P., provides that a party opposing summary judgment "may not rest upon the mere allegations . . . of his pleadings but . . . must set forth specific facts showing that there is a genuine issue for trial." Although summary judgment must be used

sparingly in antitrust actions, *see, e.g., Poller* v. *Columbia Broadcasting System, Inc.*, 368 U.S. 464, 473 (1962), Rule 56(e) remains fully applicable and significant evidence in support of a claim must be produced if a well-supported motion for summary judgment is to be defeated. *See, e.g., Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659, 686-87 (1975); *Proctor* v. *State Farm Mutual Auto Ins. Co., supra*, 561 F.2d at 275; *Modern Home Institute, Inc.* v. *Hartford Accident & Indemnity Co.*, 513 F.2d 102, 109-10 (2d Cir. 1975). As the Supreme Court has stated:

> Rule 56(e) should [not], in effect, be read out of antitrust cases and permit plaintiffs to get to a jury on the basis of the allegations in their complaint, coupled with the hope that something can be developed at trial in the way of evidence to support those allegations . . . While we recognize the importance of preserving litigants' rights to a trial on their claims, we are not prepared to extend those rights to the point of requiring that anyone who files an antitrust complaint setting forth a valid cause of action be entitled to a full-dress trial notwithstanding the absence of any significant probative evidence tending to support the complaint.

First National Bank v. *Cities Service Co.*, 391 U.S. 253, 289-90 (1968). Where, as here, the facts concerning the plaintiff's claim are not otherwise discoverable by the defendants, the plaintiff's failure to come forth with such evidence cannot be excused. Despite the extensive dis-

covery engaged in to date,[7] there is inadequate record support for finding a conspiracy among the defendants with the purpose or effect of boycotting plaintiff. The court thus concludes that the defendant's actions are exempt from application of the antitrust laws and that plaintiff's Sherman Act claim must be dismissed with prejudice.

B. *The State Law Claim for Defamation*

The sole remaining claim in the complaint is the state law claim for defamation. The complaint does not explicitly allege any jurisdictional predicate for this claim, but it appears that the principles of pendent jurisdiction are the only possible basis.[8] The court undoubtedly has the power to decide the state claim. Plaintiff's federal claim, though dismissed pre-trial, is not so obviously insubstantial as to prohibit the exercise of pendent jurisdiction, *Hagans* v. *Lavine*, 415 U.S. 528, 543 (1974), and the federal and state claims "derive from a common nucleus of operative fact." *United Mine Workers* v. *Gibbs*, 383 U.S. 715, 725 (1966). In considering whether to exercise its discretionary power to decide pendent claims, however, the court is mindful of the Supreme Court's admonition that:

---

[7] This discovery consists of the following: 1. deposition of plaintiff by NYSCA; 2. deposition of plaintiff by ULL; 3. deposition of NYSCA by plaintiff; 4. interrogatories by plaintiff to NYSCA; 5. interrogatories by plaintiff to ULL; 6. interrogatories by NYSCA to plaintiff; and 7. interrogatories by ULL to plaintiff.

[8] There is no complete diversity of citizenship among the parties; plaintiff and NYSCA are both citizens of New York for the purposes of 28 U.S.C. §1332.

Appendix B

> Needless decisions of state law should be avoided both as a matter of comity and to promote justice between the parties, by procuring for them a surer-footed reading of applicable law. Certainly, if the federal claims are dismissed before trial, even though not insubstantial in a jurisdictional sense, the state claims should be dismissed as well.

Id. at 726. Accordingly, the court declines to exercise jurisdiction over plaintiff's defamation claim, and it is dismissed for lack of subject matter jurisdiction.

CONCLUSION

Defendants' NYSCA and ULL motions for summary judgment are granted. As to plaintiff's Sherman Act claim only, the dismissal is with prejudice.

Let the Clerk enter judgment accordingly.

So Ordered.

/s/ LEE P. GAGLIARDI

U.S.D.J.

Dated: New York, New York
March 15, 1979.

APPENDIX C

Judgment

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the twenty-eighth day of May one thousand nine hundred and eighty-one.

Present: HON. IRVING R. KAUFMAN,
HON. AMALYA L. KEARSE,
HON. MYRON H. BRIGHT,
Circuit Judges,

A. ALEXANDER PIRENO,

Plaintiff-Appellant,

v.

NEW YORK STATE CHIROPRACTIC ASSOCIATION and UNION LABOR LIFE INSURANCE COMPANY,

Defendants-Appellees.

79-7307

80-7507

Appendix C

Appeal from the United States District Court for the Southern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York, and was argued by counsel.

On Consideration Whereof, it is now hereby ordered, adjudged, and decreed that the judgment of said District Court be and it hereby is reversed and the action be and it hereby is remanded to said District Court for further proceedings in accordance with the opinion of this court with costs to be taxed against the appellees.

A. Daniel Fusaro
Clerk

By: Arthur Heller
Deputy Clerk

United States Court of Appeals, Second Circuit

Filed

May 28, 1981

A. Daniel Fusaro, Clerk

APPENDIX D

The McCarran-Ferguson Act

§ 1—Declaration of policy

The Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 2—Regulation or taxation by states; effect of federal statutes; application of anti-trust laws

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Appendix D

§ 3—Limited suspension of application of antitrust laws

(a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, and the Act of June 19, 1936, known as the Robinson-Patman Antidiscrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this Act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

§ 4—Applicability of National Labor Relations Act and Fair Labor Standards Act of 1938

[Not Applicable.]

§ 5—Definition of "State"

As used in this chapter, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, Guam, and the District of Columbia.

Joint Appendix

Nos. 81-389, 81-390

Office - Supreme Court, U.S.
FILED
JAN 5 1982
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY,

Petitioner,

—v.—

A. ALEXANDER PIRENO,

Respondent.

NEW YORK STATE CHIROPRACTIC ASSOCIATION,

Petitioner,

—v.—

A. ALEXANDER PIRENO,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

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Attorney for Respondent, A. Alexander Pireno

PETITIONS FOR CERTIORARI FILED AUGUST 26, 1981
CERTIORARI GRANTED NOVEMBER 16, 1981

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	Exhibit B to O'Connor Affidavit	21a
	Exhibit C to O'Connor Affidavit	25a
6.	Order of this Court filed November 16, 1981 Allowing Certiorari in *Union Labor Life Insurance Company v. Pireno,* No. 81-389, and Consolidating Case with *New York State Chiropractic Association v. Pireno,* No. 81-390	27a
7.	Order of this Court filed November 16, 1981 Allowing Certiorari in *New York State Chiropractic Association v. Pireno,* No. 81-390, and Consolidating Case with *Union Labor Life Insurance Company v. Pireno,* No. 81-389	28a

Documents That Appear As Appendices to Union Labor Life Insurance Company's Petition for Certiorari

The following documents are not reprinted in this joint appendix because they appear on the following pages in the appendices to the printed Petition for Certiorari filed by the petitioner, Union Labor Life Insurance Company:

Opinion of the United States Court of Appeals for the Second Circuit dated May 28, 1981 ..... 1a

Opinion of the United States District Court for the Southern District of New York dated March 15, 1979 ..... 20a

Judgment of the United States Court of Appeals for the Second Circuit dated May 28, 1981 ..... 38a

Relevant Docket Entries

IN THE
UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Date	*Proceedings*
September 29, 1976	Filed complaint and issued summons.
December 15, 1976	Filed answer of defendant New York State Chiropractic Association to complaint and demand [for] trial by jury.
January 6, 1977	Filed answer of defendant Union Labor Life Insurance Company.
October 14, 1977	Filed defendant New York State Chiropractic Association affidavit and notice of motion for an order dismissing complaint and rendering summary judgment in favor of defendant returnable October 14, 1977.
January 25, 1978	Filed defendant Union Labor Life Insurance Company's notice of motion re: summary judgment and dismissal of the complaint returnable February 2, 1978.
March 16, 1979	Filed Opinion No. 48355 . . . Defendants' NYSCA and ULL motions for summary judgment are granted. As to plaintiff's Sherman Act claim only, the dismissal is with prejudice. Let the Clerk enter judgment accordingly. Gagliardi, J.

Date	*Proceedings*
March 19, 1979	Filed Partial Judgment—Ordered that the complaint is dismissed as to defendants New York State Chiropractic Association and Union Labor Life Insurance Company only and that plaintiff's Sherman Act claim only is dismissed, with prejudice.
August 15, 1979	Filed Notice of Appeal from order granting defendants' motion[s] for summary judgment entered March 15, 1979.

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Date	*Proceedings*
August 22, 1979	Notice of appeal and district court docket entries on behalf of Pireno filed.
May 28, 1981	Judgment reversed and remanded. Published signed opinion, Kearse, C.J.
May 28, 1981	Judgment filed.

Complaint

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

76 Civ. 4309 (LPG)

A. ALEXANDER PIRENO,

Plaintiff,

—against—

NEW YORK STATE CHIROPRACTIC ASSOCIATION, UNION LABOR LIFE INSURANCE COMPANY and INTERNATIONAL CHIROPRACTORS ASSOCIATION,

Defendants.

COMPLAINT

I. JURISDICTION AND VENUE

1. This complaint is filed under Section 4 of the Act of Congress of October 15, 1914, as amended (15 U.S.C. § 15), commonly known as the Sherman Act, in order to prevent and restrain the continuing violation by the defendants, as hereinafter alleged, of Section I of the Act of Congress of July 2, 1890 (15 U.S.C. § 1).

2. The defendant, NEW YORK STATE CHIROPRACTIC ASSOCIATION, (hereinafter referred to as "NYCA"), maintains an office, transacts business and is found within this District.

3. The defendant, UNION LABOR LIFE INSURANCE COMPANY (hereinafter "Union"), maintains an office, transacts business and is found within this District.

4. The defendant, INTERNATIONAL CHIROPRACTORS ASSOCIATION (hereinafter "ICA"), transacts business within this District.

5. The acts complained of originated and occurred within this District.

II. DEFENDANTS

6. The defendant NYCA is, upon information and belief a not-for-profit corporation organized under the laws of the State of New York and has its principal place of business in New York, New York. Its membership consists solely of licensed Chiropractors.

7. The defendant UNION is a licensed insurance company, organized in Maryland and having its principal place of business in New York, New York. It is authorized to and provides, amongst other things, insurance coverage to individuals and members of groups for medical and chiropractic costs and expenses (commonly known as "health insurance"), in, upon information and belief, more than half the states in the United States.

8. The defendant, ICA is an association having its principal office in Davenport, Iowa. Its membership consists of chiropractors residing and practicing in all of the several states of the United States.

III. CO-CONSPIRATORS

9. Various persons and organizations, not made defendants herein, have participated as co-conspirators in the violations hereinafter alleged and have performed acts and have made statements in furtherance thereof. Such co-conspirators include, but are not limited to, members of defendants NYCA and ICA.

IV. TRADE AND COMMERCE

10. The memberships of NYCA and ICA consists of Chiropractors located in New York State and throughout the United States. Those Chiropractors provide health care services to individuals located in New York State and throughout the United States. Those members furnish chiropractic services to persons residing in the states in which such members practice and in other states, so that in many instances, individuals obtaining treatment and services from such members are caused to come from one of the several states to another.

11. The defendant UNION, is engaged in the business of providing insurance coverage for health care, by the sale of insurance policies to individuals within the various states of the United States. This service facilitates, directs and has an effect upon the conduct of interstate business and contributes directly to the flow of persons, money and services in interstate commerce.

12. The activities of defendants NYCA and ICA and their members and defendant UNION, as described herein, are within the flow of interstate commerce, and have a substantial effect upon interstate commerce.

V. VIOLATION ALLEGED

13. For several years past, and continuing up to and including the date of the filing of this complaint, the defendants and co-conspirators have been engaged in a combination and conspiracy in unreasonable restraint of the aforesaid trade and commerce in violation of Section I of the Sherman Act. Said unlawful combination in conspiracy is continuing and will continue unless the relief hereinafter prayed for is granted.

14. The aforesaid combination and conspiracy has consisted of a continuing agreement, understanding and concert of

action among the defendants and co-conspirators, the substantial terms of which have been and are: (a) Since in or about December, 1972, defendant NYCA, through its Peer Review Committee, entered into an arrangement with the defendant UNION, amongst others, whereby the said Peer Review Committee would provide, as a gratuitous service to UNION, a review of chiropractic claims submitted to UNION by its insureds for the purpose of determining and setting a fee for the services rendered by independent, licensed, qualified Doctors of Chiropractic, including but not limited to the plaintiff herein. (b) From in or about December, 1972, and continuing through the present date, the said two defendants proceeded to engage in a conspiracy whereby claims for insurance proceeds under health policies issued by UNION to its insureds for chiropractic services, were uniformly submitted to the said Peer Review Committee for evaluation. Such evaluation included but was not limited to, setting and establishing a fee for the services rendered by the plaintiff to the insured whereby defendant insurance company limited its payment under its policy of insurance, to the said fixed fee. (c) Since in or about 1975, defendant ICA, entered into an agreement with defendant UNION, amongst others, whereby ICA provided, as a gratuitous service, the insurance company with a review of chiropractic claims submitted to UNION by its insureds for the purpose of determining and setting a fee for the services rendered by independent, licensed, qualified Doctors of Chiropractic, including but not limited to the plaintiff herein. (d) Since in or about 1975, and continuing through the present date, the said defendants proceed to engage in a conspiracy whereby claims for insurance proceeds under health policies issue by UNION to its insureds for chiropractic services were uniformly submitted to ICA for evaluation. Such evaluation included but was not limited to setting and establishing a fee for the services rendered by the plaintiff to the insureds of UNION, whereby UNION limited its payment under its policy of insurance to the said fixed fee. (e) In furtherance of the aforesaid conspiracy, defendants ICA and NYCA made evaluations and determinations as to the nature, quantity and

quality of the treatment rendered to each said insured by the plaintiff and based upon such evaluation, defendant UNION further limited its payments under its insurance policies to the said insureds. (f) The evaluations so made by defendants NYCA and ICA were uniformly forwarded to the insureds of UNION all of whom, were or are patients of the plaintiff.

15. For the purpose of effectuating the aforesaid combination and conspiracy, the defendants and co-conspirators have done those things which, as hereinbefore alleged, they agreed to do.

VI. EFFECTS

16. The aforesaid combination and conspiracy has had the following effects, among others: (a) Purchasers of chiropractic services from the plaintiff have been deprived of the benefits of free and open competition in the acquisition of such services; (b) Plaintiff has been restrained in his ability to make chiropractic services readily and fully available to the public; (c) Purchasers of chiropractic services from the plaintiff have been deprived of the insurance coverage to which they are entitled by defendant UNION under the terms of its insurance policies; (d) Purchasers of chiropractic services have been deprived of the benefit of free and open competition in the sale of such services; (e) Plaintiff has been and continues to be defamed and libled in the practice of his profession by the statements furnished to insureds by the defendants and co-conspirators in furtherance of the conspiracy set forth hereinabove.

WHEREFORE, plaintiff prays:

1. That the Court adjudge and decree that the defendants have engaged in an unlawful combination and conspiracy in restraint of the aforesaid trade and commerce in violation of Section I of the Sherman Act.

2. That the defendants, their officers, employees and agents, and all of the persons acting or claiming to act on their behalf, be enjoined and restrained from continuing, maintaining or renewing the aforesaid combination and conspiracy, and from entering into, maintaining, or participating in any agreement, understanding, plan, program or other arrangement having the purpose or effect of continuing, maintaining or renewing such combination and conspiracy.

3. That the plaintiff be awarded money damages in the sum of ONE MILLION ($1,000,000) DOLLARS by reason of the libel and defamation of his professional character and integrity as aforementioned.

4. That the defendant UNION be required to cancel those provisions of its insurance policies and every other rule or statement of policy which has the purpose or effect of suppressing or restricting free and open competition in the sale of chiropractic services.

5. That the plaintiff have such other and further relief as the nature of the case may require and the Court may deem just and proper under the circumstances.

6. That the plaintiff recover the costs of this suit.

7. That the plaintiff recover counsel fees in connection with the prosecution of this suit.

Dated: New York, New York
September 28, 1976

/s/ A. ALEXANDER PIRENO
A. Alexander Pireno

/s/ EDWARD S. PATTERSON
By: Edward S. Patterson
Attorney for the Plaintiff
A Member of the Bar of this Court
295 Madison Avenue
New York, N.Y. 10017
(212) 686-6622

Answer of Union Labor Life Insurance Company

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Civil Action No.

76C4309 L.P.G.

A. ALEXANDER PIRENO,

Plaintiff,

—against—

NEW YORK STATE CHIROPRACTIC ASSOCIATION, UNION LABOR LIFE INSURANCE COMPANY and INTERNATIONAL CHIROPRACTORS ASSOCIATION,

Defendants.

ANSWER

Defendant Demands Trial By Jury

Defendant Union Labor Life Insurance Company (hereinafter referred to as "Union"), by its attorneys Werner, Kennedy & French, as and for its answer to the complaint herein alleges as follows:

1. Answering paragraph 1 of the complaint, admits the filing of the complaint herein but denies the violations of law alleged therein insofar as said allegations refer to defendant Union.

2. Denies knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraphs 2, 4, 5, 6, 8, 9 and 10 of the complaint.

3. Denies each and every allegation contained in paragraph 7 of the complaint, except admits that defendant Union is a licensed insurance company, organized in Maryland and having its principal place of business in New York, and that it is authorized to and provides, among other things, health insurance coverage to certain groups and individuals in more than half the states in the United States.

4. Denies knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph 11 of the complaint, except admits defendant Union is engaged in the business of providing insurance coverage for health care in certain states of the United States.

5. Denies each and every allegation contained in paragraphs 12, 13, 14, 15 and 16 of the complaint, except admits that defendant Union during the times alleged in the complaint consulted and received advice from co-defendants New York State Chiropractic Association or International Chiropractors Association regarding certain chiropractic treatment rendered to persons covered by its health insurance policies.

AS AND FOR A FIRST AFFIRMATIVE DEFENSE

6. Plaintiff has failed to state a claim against defendant Union upon which relief can be granted.

AS AND FOR A SECOND AFFIRMATIVE DEFENSE

7. This court lacks jurisdiction over the subject matter of this action.

AS AND FOR A THIRD AFFIRMATIVE DEFENSE

8. With respect to the alleged violation of Section I of the Sherman Act, 15 U.S.C.A. § 1 (1973), plaintiff has not alleged nor has he sustained damages to his business or property caused by any acts of defendant Union in violation of said law.

AS AND FOR A FOURTH AFFIRMATIVE DEFENSE

9. With respect to the alleged violation of Section I of the Sherman Act, 15 U.S.C.A. § 1 (1973), plaintiff has not alleged injury to the public nor to interstate commerce resulting from acts of defendant Union in violation of said law.

AS AND FOR A FIFTH AFFIRMATIVE DEFENSE

10. With respect to the alleged violation of Section I of the Sherman Act, 15 U.S.C.A. § 1 (1973), plaintiff's action is barred by the provisions of the McCarran-Ferguson Act, 15 U.S.C.A. § 1011-1015 (1976).

AS AND FOR A SIXTH AFFIRMATIVE DEFENSE

11. With respect to the declaratory and other relief requested by plaintiff, he has failed to allege nor is there in fact a justiciable controversy.

AS AND FOR A SEVENTH AFFIRMATIVE DEFENSE

12. With respect to the injunctive and other equitable relief requested by plaintiff, he has an adequate remedy at law by means of an action to recover any damages he may claim to have sustained.

AS AND FOR AN EIGHTH AFFIRMATIVE DEFENSE

13. With respect to the injunctive and other equitable relief requested by plaintiff, he freely and knowingly participated and cooperated in the activities of the co-defendants and has acquiesced in the actions complained of.

AS AND FOR A NINTH AFFIRMATIVE DEFENSE

14. Plaintiff is not entitled to the equitable relief sought because, on information and belief, his reasons for seeking to

stop the peer review process are solely to enrich himself at the expense of defendant Union and his patients while at the same time seeking to avoid any review of the adequacy or appropriateness of his treatment by a peer review procedure.

AS AND FOR A TENTH AFFIRMATIVE DEFENSE

15. With respect to the injunctive and other equitable relief requested by plaintiff, he refrained, with notice of all the facts and acts of the defendants alleged in the complaint, from commencing this action until September 29, 1976, and he has thereby been guilty of such laches as should in equity bar him from maintaining this action.

AS AND FOR AN ELEVENTH AFFIRMATIVE DEFENSE

16. Plaintiff's action on some of the alleged violations of Section I of the Sherman Act, 15 U.S.C.A. § 1, (1973) is barred by the provisions of 15 U.S.C.A. § 15 (b) (1973).

AS AND FOR A TWELFTH AFFIRMATIVE DEFENSE

17. On information and belief, the alleged defamation and libel was privileged and constituted fair comment on plaintiff's professional activities.

AS AND FOR A THIRTEENTH AFFIRMATIVE DEFENSE

18. On information and belief, the alleged defamation and libel was true.

AS AND FOR A FOURTEENTH AFFIRMATIVE DEFENSE

19. Plaintiff's alleged cause of action for defamation and libel is barred by the statute of limitations of the State of New York.

AS AND FOR A FIFTEENTH AFFIRMATIVE DEFENSE

20. Plaintiff has not alleged nor has he sustained any damages as a result of the alleged defamation and libel.

AS AND FOR A SIXTEENTH AFFIRMATIVE DEFENSE

21. On information and belief, plaintiff consented to the alleged defamation and libel.

AS AND FOR A SEVENTEENTH AFFIRMATIVE DEFENSE

22. By virtue of the terms of defendant Union's policy of insurance and the provisions of law, to which said defendant will refer more fully at the trial herein, defendant Union is obligated to pay only the reasonable charges for necessary medical care and services, subject to certain schedules and maximum benefits.

AS AND FOR AN EIGHTEENTH AFFIRMATIVE DEFENSE

23. On information and belief, the alleged defamation and libel was made without malice, and plaintiff has not alleged malice.

AS AND FOR A CROSS-CLAIM AGAINST DEFENDANTS NEW YORK STATE CHIROPRACTIC ASSOCIATION AND INTERNATIONAL CHIROPRACTORS ASSOCIATION

24. If plaintiff recovers a judgment against defendant Union, such liability will have been brought about and caused solely by reason of the actions of defendants New York State Chiropractic Association and International Chiropractors Association.

25. By reason of the foregoing, said defendants, or any of them, will be wholly liable over to defendant Union for the

amount of any verdict or judgment which may be recovered by plaintiff, together with the costs and disbursements of this action.

WHEREFORE, defendant Union Labor Life Insurance Company demands judgment dismissing each and every cause of action alleged in the complaint and said defendant further demands judgment over and against defendants New York State Chiropractic Association and International Chiropractors Association for any sum which shall or may be recovered herein by plaintiff against defendant Union, together with the costs and disbursements of this action.

/s/ AKIN M. FRENCH
Akin M. French
Werner, Kennedy & French
Attorneys for Defendant
Union Labor Life Insurance Company
19 Rector Street
New York, New York 10006
(212) 425-7525

(Affidavit of service omitted in printing).

Affidavit of Raymond V. O'Connor, Sworn to January 11, 1978, in Support of Motion by Union Labor Life Insurance Company for Summary Judgment and Dismissal of the Complaint

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

76 Civ. 4309 (LPG)

A. ALEXANDER PIRENO,

Plaintiff,

—against—

NEW YORK STATE CHIROPRACTIC ASSOCIATION, UNION LABOR LIFE INSURANCE COMPANY and INTERNATIONAL CHIROPRACTORS ASSOCIATION,

Defendants.

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

AFFIDAVIT

Raymond V. O'Connor, being duly sworn, deposes and says:

1. I am Second Vice President and Counsel of the defendant Union Labor Life Insurance Company ("Union") and have been since 1968. I have been in the employ of Union since 1952 and have been in its legal department since 1958. I have been admitted to the practice of law in the State of New York since 1950. My responsibilities as Second Vice President and Counsel include all home office legal matters, including those relating to litigation, underwriting, taxes, claims and compliance with New York and other state insurance laws and regulations. I am

fully familiar with the facts and circumstances of this lawsuit and have personal knowledge of the facts set forth hereinafter. I make this affidavit in support of Union's motion for summary judgment dismissing the complaint under Rule 56 and to dismiss the complaint under Rules 12(b) (1) and (6) of the Federal Rules of Civil Procedure.

2. The summons and complaint in this action were served on Union on October 6, 1976. Issue was joined by service of Union's answer on January 5, 1977, and the same has been filed with the Clerk of the Court.

3. Union is licensed and sells insurance in New York and 43 other states. Its business consists principally of the writing of health, accident and life insurance for groups.

4. Union is required by the New York Insurance Law and the regulations promulgated thereunder by the Superintendent of Insurance to provide health coverage at a reasonable cost. All policy forms issued by Union are filed with and approved by the Superintendent under Insurance Law § 154(1) (McKinney 1966). He may disapprove any form

> "(1) if the benefits provided therein are unreasonable in relation to the premium charged, or (2) if any such form contains provisions which . . . are . . . contrary to law or to the public policy of this state." *Id.*

Attached hereto as Exhibit A are letters dated February 5, 1964, September 26, 1961 (both of which apply to insured Local 580, Policy No. C 2338), September 18, 1970 (American Federation of Television and Radio Artists, Policy No. C 2856), April 4, 1975, May 16, 1972 (both of which apply to insured Paper and Mail Deliverers Policy No. C 3015), April 4, 1975, February 15, 1973 (both of which apply to insured Publishers Pressmen, Policy No. C 3076), September 26, 1973 and December 9, 1976 (both of which apply to insured Actors Equity, Policy No. C 3033), each from the New York Insurance Department together with the Union forms which were approved by said letters. These forms were used to provide

coverage to the groups whose members were patients of plaintiff.

By the terms of New York Insurance Law § 221(5) (e) (McKinney Supp. 1976), Union is required to reimburse insureds for chiropractic treatment whenever a policy "provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor. . . ."

Union's premium rates are filed with the Superintendent under New York Insurance Law §§ 162(2) and 221(7) (McKinney 1966) and a regulation designated 11 NYCRR 52.40(e). Included in its rate filing must be "an outline of the essential benefits, coverages, limitations and exclusions to which the rate applies." § 52.40(e) (2) (iii).

Union's premium rates are based primarily on expenses and loss experience. Union's minimum anticipated loss ratio is fixed by the Superintendent. 11 NYCRR 52.45(c). Therefore, Union is required to administer claims as efficaciously as possible so as to minimize loss experience.

5. Union's policies filed with and approved by the Superintendent of Insurance provide certain basic benefits generally covering non-occupational sickness or accidental bodily injury. In addition, the approved forms provide for major medical and supplemental coverages if selected by the insured. Patients of plaintiff who submitted claims to Union ordinarily were members of insured groups which had selected only the major medical coverage as indicated by the forms attached hereto as Exhibit A. As indicated by the summary specimen page attached as Exhibit B, this coverage provides, in pertinent part, as follows:

> "Upon receipt of due proof that any Person has incurred Covered Charges as a result of a nonoccupational sickness or injury sustained while insured for these Major Medical benefits, the Company will pay an amount equal to of Covered Charges in excess of the Deductible Amount shown below and subject to the limitations and provisions of this policy."

"Covered Charges" are defined as "the *reasonable charges* . . . for *necessary* medical care and services. . . ." (emphasis supplied).

The type of care and services are defined in the policy. Covered charges must be for "services, supplies, and treatment prescribed as necessary by a legally qualified physician practicing within the scope of his license. . . ." Furthermore, reimbursement under this coverage is also limited to a maximum payment as agreed to by the Company and the group insured (Exhibit B).

The third type of coverage for which patients of plaintiff may have been entitled to reimbursement from Union is the supplemental accident expense coverage. As indicated by the summary specimen page attached as Exhibit C, this coverage provides reimbursement to the insured or his or her dependent for charges for treatment for "accidental bodily injuries on account of a nonoccupational accident" over and above the amount of reimbursement provided by the basic coverages, but not in excess of the maximum payments listed in the schedule agreed upon by the insureds. Furthermore, this coverage contains the following limitation:

> "The charges referred to herein shall include *only those charges not in excess of the regular and customary charges* for the services and treatment furnished." (Exhibit C) (emphasis supplied).

6. It is Union's policy to keep costs at a minimum in the administration of claims in order to provide insurance at reasonable rates as required by Insurance Law § 154(1). As part of this policy, Union accepted the invitation of the New York State Chiropractic Association ("NYSCA") (Exhibit D) to use its peer review services for claims involving questions of whether the treatments rendered were within the "reasonable" and "necessary" and "regular and customary" limitations of the major medical and supplemental coverages. The peer review services also were used on occasion for other questions of coverage, such as whether the treatment rendered was within the scope of the chiropractor's license.

7. It has been Union's understanding and experience that members of NYSCA's peer review committees are well qualified, have had substantial experience in their respective fields, and represent a cross-section of different theories of treatment and customary practices in various localities. The committees have provided an essential expertise in the interpretation and application of the policy coverages and limits outlined above.

8. Without the peer review services provided by the NYSCA it might be necessary for Union to retain on its staff at substantial expense one or more experienced chiropractors. In the event that the opinion of the staff chiropractor were disputed by the treating chiropractor, it then would be necessary to refer the dispute to a mediator such as the NYSCA Peer Review Committee. The opinion of a single staff chiropractor would inevitably be much less meaningful than the opinion of an independent committee composed of members of established professional stature.

/s/ RAYMOND V. O'CONNOR
Raymond V. O'Connor

(Jurat omitted in printing).

(Exhibit A to O'Connor Affidavit omitted in printing).

Exhibit B to O'Connor Affidavit

MAJOR MEDICAL EXPENSE PROVISIONS

BENEFITS. Upon receipt of due proof that any Person has incurred Covered Charges as a result of a non-occupational sickness or injury sustained while insured for these Major Medical benefits, the Company will pay an amount equal to of Covered Charges in excess of the Deductible Amount shown below and subject to the limitations and provisions of this policy.

DEDUCTIBLE AMOUNT. The deductible shall be equal to the sum of

(a) the Basic Benefits Deductible as described below,

For the purpose of this policy, the Basic Benefits Deductible means the amount of benefits payable with respect to Covered Charges under this policy,

It is further provided that if any or all of an individual's Cash Deductible for a Benefit Year is deducted for Covered Charges incurred during the last three months of the Benefit Year, the Cash Deductible for such individual shall be reduced within the subsequent Benefit Year by the amount so deducted.

MAXIMUM PAYMENT. The maximum amount payable under these Major Medical Expense Provisions with respect to all illnesses or injuries of any one individual during such individual's entire lifetime shall be . However, if at any time has been paid under these provisions with respect to an individual and the individual is not then qualifying for a major medical expense claim, the individual may have his Maximum Payment reinstated to upon submission, at his own expense, of evidence of insurability satisfactory to the Company.

"BENEFIT YEAR" is defined as the period

COVERED CHARGES. "Covered Charges" referred to herein means the reasonable charges outlined below for necessary medical care and services which are ordered by a legally qualified physician:

(1) charges made by a hospital, as defined below, provided that the includable room and board charges may not exceed

"Hospital" means a short term, acute, general hospital, which (a) is primarily engaged in providing by or under the continuous supervision of physicians, to in-patients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons, (b) has organized departments of medicine and major surgery, (c) has a requirement that every patient must be under the care of a physician or dentist, (d) provides twenty-four hour nursing service by or under the supervision of a registered professional nurse (R.N.), (e) is duly licensed by the agency responsible for licensing such hospitals, and (f) is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, or rehabilitory care.

(2) charges for diagnosis, treatment, and surgery by a legally qualified physician practicing within the scope of his license.

(3) charges made by a registered graduate nurse for private duty nursing services, other than one who resides in the Individual's home or who is a blood relative.

(4) charges for the following orthopedic or prosthetic appliances: artificial limbs or eyes for the initial replacement of natural limbs or eyes; initial truss, brace or support; cast, splints, crutches; rental of an iron lung,

wheelchair or hospital type bed; oxygen and the rental of equipment for its administration except that charges in excess of the purchase cost thereof shall be excluded.

(5) charges for the following: local ambulance service, X-ray services, laboratory tests, anesthesia and the adminstration thereof, the use of radium and radio-active isotopes, physio-therapy, and similar services and treatment,

EXTENDED BENEFITS ON TERMINATION. Benefits are payable for Covered Expenses incurred on any day during the Benefit Year in which the individual's insurance coverage is terminated and during the next succeeding Benefit Year provided the medical expenses are incurred with respect to an accidental bodily injury or sickness on account of which the individual is totally disabled at the time his insurance is terminated and is continuously disabled to the date each medical expense is incurred, and provided that the individual is not entitled to benefits for such expenses under any other policy of group insurance or any group Blue Cross or Blue Shield plan on the date each medical expense is incurred.

LIMITATIONS. "Covered Charges" shall in no event be deemed to include charges for services, supplies or treatment:

1. unless such services, supplies, and treatment were prescribed as necessary by a legally qualified physician practicing within the scope of his license,
2. during confinement in a hospital owned or operated by the Federal Government,
3. that the insured individual is not required to pay,
4. if they were incurred on account of
   a. pregnancy,
   b. services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes, except to tumors or cysts or except as required because of accidental injury to natural teeth occuring while insured hereunder,

c. elective or cosmetic surgery, except as required because of accidental injury occurring while insured hereunder,

d. eye refractions, eyeglasses or the fitting thereof

e. hearing aids or the fitting thereof,

f. war or an act of war, declared or undeclared; participation in a felony, riot or insurrection.

g. accidental bodily injury arising out of and in the course of the individual's employment,

h. occupational disease; for the purpose of this Policy the term "occupational disease" shall mean a disease for which the individual with regard to whom a claim is submitted, is entitled to benefits under the applicable Workmen's Compensation Law, Occupatinal Disease Law, or similar legislation,

PAYMENT OF BENEFITS. Upon compliance with the Claims provisions, benefits will be paid as they accrue

GMM-2600-100.120

Exhibit C to O'Connor Affidavit

SUPPLEMENTAL ACCIDENT EXPENSE PROVISIONS

SUPPLEMENTAL ACCIDENT EXPENSE BENEFITS. Upon receipt of due proof that any Person, while insured under this provision, shall have sustained accidental bodily injuries on account of a non-occupational accident, and as a result thereof shall have incurred any of the following charges,

1. Charges made by a duly constituted and lawfully operated hospital for room and board and other services,
2. Charges made by a legally qualified physician for diagnosis, treatment or surgery,
3. Charges made by a private duty nurse for private duty nursing service, or
4. Charges for X-rays and laboratory tests,

then, the Company will, subject to the limitations and provisions of this Policy, pay such Person the amount of such charges so incurred within ninety days of the accident which are in excess of the total amount of Hospital, Surgical and Medical Benefits payable to such Person in connection with such injuries under all other provisions of this Policy, provided, however, that the total amount payable under this provision shall not exceed the Maximum Payment set forth in the Schedule of Insurance.

The charges referred to herein shall include only those charges not in excess of the regular and customary charges for the services and treatment furnished.

LIMITATIONS. No payment shall be made under the paragraph entitled Supplemental Accident Expense Benefits for charges incurred on amount of

A. hospital confinement, treatment, X-rays, laboratory tests, or services which are not recommended and approved by a legally qualified physician, or

B. bodily injuries arising out of and in the course of the Person's employment.

PAYMENT OF BENEFITS. Upon compliance with the Claims provision, benefits will be paid as they accrue.

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Supp. Acc.

(Exhibit D To O'Connor Affidavit omitted in printing).

Order of This Court Filed November 16, 1981 Allowing Certiorari in *Union Labor Life Insurance Company v. Pireno*, No. 81-389, and Consolidating Case with *New York State Chiropractic Association v. Pireno*, No. 81-390

SUPREME COURT OF THE UNITED STATES

No. 81-389

UNION LABOR LIFE INSURANCE COMPANY,

Petitioner,

—v.—

A. ALEXANDER PIRENO

ORDER ALLOWING CERTIORARI. Filed November 16, 1981

The petition herein for a writ of certiorari to the United States Court of Appeals for the Second Circuit is granted. The case is consolidated with case No. 81-390, *New York State Chiropractic Association* v. *A. Alexander Pireno,* and a total of one hour is allotted for oral argument.

Order of This Court Filed November 16, 1981 Allowing Certiorari in *New York State Chiropractic Association v. Pireno*, No. 81-390, and Consolidating Case with *Union Labor Life Insurance Company v. Pireno*, No. 81-389

SUPREME COURT OF THE UNITED STATES

No. 81-390

NEW YORK STATE CHIROPRACTIC ASSOCIATION,

Petitioner,

—v.—

A. ALEXANDER PIRENO

ORDER ALLOWING CERTIORARI. Filed November 16, 1981

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Opposition

No. 81-389

No. 81-390

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

NEW YORK STATE CHIROPRACTIC ASSOCIATION, and UNION LABOR LIFE INSURANCE COMPANY,

Petitioners,

v.

A. ALEXANDER PIRENO,

Respondent.

BRIEF OF RESPONDENT A. ALEXANDER PIRENO IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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Question Presented

Whether the practice of peer review committees of associations of health care professionals in evaluating the reasonableness and propriety of reimbursement claims under health insurance policies for health insurers is "the business of insurance" within the meaning of §2(b) of the McCarran-Ferguson Act, 15 U.S.C. §§1011-1015 (1976).

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A. ALEXANDER PIRENO,

Respondent.

BRIEF OF RESPONDENT A. ALEXANDER PIRENO IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

This brief is submitted on behalf of respondent A. Alexander Pireno in opposition to the petitions for writs of certiorari (hereinafter referred to in the singular) filed by petitioners New York State Chiropractic Association ("NYSCA") and Union Labor Life Insurance Company ("ULL"). A. Alexander Pireno concurs in petitioners' statements under the headings *Opinions Below, Jurisdiction, Statute Involved,* and, for the purposes of this brief only, in the *Statement of the Case,* since respondent does not agree with many of the conclusory statements contained therein, but considers them irrelevant to this proceeding.

REASONS FOR DENYING THE WRIT

I. A conflict between the decision of the Second Circuit with a decision of the Fourth Circuit does not require a resolution by this Court.

There is no gainsaying that the decision of the Second Circuit below conflicted with the prior decision of the Fourth Circuit in *Bartholomew* v. *Virginia Chiropractic Association*, 612 F.2d 812 (4th Cir. 1979), cert. denied, 446 U.S. 938 (1980). That such conflict mandates a review by this Court of the decision below does not necessarily follow therefrom.

Petitioners argue that the vulnerability of health insurers and professional associations to antitrust suits will have a chilling effect on the peer review practice at issue in this action. Indeed, petitioner NYSCA urges that "(n)o professional society or group of professionals . . . would care to do so (engage in peer review of fees) without the protection of the McCarran Act exemption." (NYSCA Pet. at 9) This argument fails on two points: it is factually untrue, since there apparently has been no diminution of in peer review activity, at least in New York, since the Second Circuit decision; and, it is irrelevant to the within proceeding in that it speaks more to the merits of the underlying claim of antitrust violation than it does to the question of review by this Court of the decision below. Clearly, the accuracy of the allegation itself, and the probative value thereof, are matters more in the province of a trial court, and should not be predetermined here as urged by petitioners.

II. The definition of "business of insurance" under the McCarran-Ferguson Act as established by this Court in *Royal Drug* is clear and unequivocal.

In adopting a narrow definition of the term "business of insurance" in *Royal Drug,* this Court followed the general rule that even express exemptions from antitrust laws are to be strictly construed. Thus, the Court noted that the primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk. *Royal Drug,* at p. 1073, citing Couch on Insurance, Vol. 1 §2. Secondarily, this Court focused on another commonly understood aspect of the "business of insurance", the relationship between the insurer and the insured, in terms of the reliability of the insurer, and the interpretation and enforcement of the insurance policy. Using the foregoing criteria, this Court found that the pharmacy agreements in question were not "the business of insurance", and were therefore not subject to the McCarran Act exemption.

The opinion below, by Judge Kearse, provides a comprehensive and penetrating analysis of *Royal Drug.* By contrast, the Fourth Circuit in *Bartholomew, supra,* gave only cursory treatment to the "business of insurance" question, concluding that "(f)or an especially clarifying discourse of this and the related issues *see generally Pireno* v. *New York Chiropractic Ass'n,* No. 76-4309 (S.D.N.Y. March 15, 1979)." The Fourth Circuit then, essentially did nothing more than adopt the lower court decision here which was subsequently unanimously reversed by the Second Circuit.

Since *Royal Drug,* with the sole exceptions of *Bartholomew, supra,* and *Ratino* v. *Medical Service of the District of Columbia,* 1981 Trade Cases §64,144 (D.Md. 1981), in which the District Court felt itself bound by the Fourth

Circuit decision in *Bartholomew, supra,* the courts have recognized and adhered to the narrow construction laid down by this Court in *Royal Drug,* finding that the activities complained of in each such case were not "the business of insurance", and accordingly, not subject to the McCarran Act exemption. *Arizona* v. *Maricopa County Medical Society,* 643 F.2d 553 (9th Cir. 1980), cert. granted, —— U.S. ——, 101 S.Ct. 1512 (1981); *Virginia Acadamy of Clinical Psychologists* v. *Blue Shield, et al.,* —— F.2d —— (Fourth Cir., June 16, 1980); *Liberty Glass Co.* v. *Allstate Insurance Co.,* 1980-1 Trade Cases §63,014 (Fifth Cir., Nov. 21, 1979); *National Gerimedical Hospital and Gerontology Center* v. *Blue Cross,* 1979-2 Trade Cases §62,739 (S.D.N.Y., June 22, 1979) (*dicta*); *Hoffman* v. *Delta Dental Plan of Minnesota,* 1981 Trade Cases §64,138 (D. Minn. 1981) (citing *Pireno*); and *Owens* v. *Aetna Life and Casualty Co., et al.,* 1981 Trade Cases §64,154 (3rd Cir. 1981).

It would seem then, that the conflict in Circuits relied on by petitioners in the within proceeding, could best be resolved by a reexamination by the Fourth Circuit of its erroneous interpretation and application of the principles set down by this Court in *Royal Drug,* rather than burdening this Court with a review of the decision below.

CONCLUSION

For the reasons described above, we respectfully request that the petitions for writs of certiorari be denied.

October 19, 1981

Respectfully submitted,

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Petitioner's Reply Brief

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NO. 81-389

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY,

Petitioner,

v.

A. ALEXANDER PIRENO,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF FOR PETITIONER

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NO. 81-389

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Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF FOR PETITIONER

The petitioner, Union Labor Life Insurance Company, respectfully submits this reply brief to the Brief of Respondent A. Alexander Pireno in Opposition to the Petition for a Writ of Certiorari.

As noted by the Brief of Respondent at 3, the District Court of Maryland in *Ratino* v. *Medical Service of the District of Columbia,* 1981-1 Trade Cas. (CCH) ¶ 64,144 (D. Md. 1981), recently has followed the holding of the Fourth Circuit in *Bartholomew* v. *Virginia Chiropractors*

Association, 612 F.2d 812 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980). *Bartholomew* directly conflicts with the holding of the Second Circuit below.

Bartholomew also now has been followed in a factually identical case by the District Court of the Western District of Washington in *Gerimonte* v. *Washington State Chiropractors Association*, No. C81-40R (W.D. Wash. Oct. 16, 1981). The decision, a copy of which is annexed hereto as an appendix, indicates that the District Court had carefully examined the Second Circuit's opinion below but did "not find it persuasive." *Id.*, slip op. at 4-5, App. at 6a.

The well-reasoned decision of the District Court in *Gerimonte* states, in pertinent part, as follows:

> The peer review system serves to determine the extent of the insurers' contractual obligations to their policyholders. The insurance contracts limit reimbursement to usual, customary, and reasonable charges for necessary health care services rendered. The determination of usual and customary charges is done through the mechanism of the peer review committee. The interpretation of the terms of the policy, which will in turn determine the rights of the policyholder, is of direct and immediate concern to the insured. When Congress enacted the McCarran-Ferguson Act it was concerned with precisely this relationship between insurer and insured —the "core of the 'business of insurance.'" The focus of Congress was "on the relationship between the insurance company and the policyholder." *Royal Drug*, 440 U.S. at 215, *citing*, *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1968).

In *Royal Drug* Blue Shield entered into agreements with pharmacies obligating the pharmacists to provide drugs to Blue Shield policyholders at a fixed rate. The peer review system used by the insurance companies here merely establishes what the insurers will pay their policyholders under their contracts. The chiropractors are free to demand whatever fee they wish; no policyholder is refused reimbursement for any fees of any chiropractor so long as the fees are usual and customary. The range of fees which are usual and customary is determined by the WCA. Unlike the situation in *Royal Drug,* the rates are not dictated by the insurers. If the usual and customary fees rise or if the usual and customary services offered by chiropractors expand, the insurance companies will necessarily reimburse their policyholders for those fees. The service provider agreements of *Royal Drug* simply are not present here. The freedom of chiropractors to impose higher fees and collect the difference from their patients, as plaintiffs have, in fact, done, demonstrates that insurer defendants have determined nothing other than the extent of their own contractual obligations to their policyholders. The peer review system fits squarely within the "traditional model" of the insurance contract. *Id.,* slip op. at 5-6, App. at 6a-7a.

Thus, the conflict between the circuits cannot be resolved by a reexamination by the Fourth Circuit of its decision in *Bartholomew* as the Brief of Respondent at 4 suggests. A clear split of interpretation of this Court's decision in *Royal Drug* has emerged among the federal courts. The conflict has created widespread confusion and uncertainty not only with respect to whether peer review will continue

to be available to health insurers and their policyholders, but as to whether, as the decision of the Second Circuit indicates, the entire insurance claims settlement process is no longer to be deemed part of the "business of insurance" under the McCarran-Ferguson Act antitrust exemption. Under the circumstances, the need for a writ of certiorari to the Second Circuit is manifest.

For the foregoing reasons and those set forth in the petition, it is respectfully submitted that the petition for a writ of certiorari should be granted.

Respectfully submitted,

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[Appendix Follows]

Appendix

APPENDIX

Order Granting Defendants' Motion to Dismiss

(Entered—October 19, 1981)

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

No. C81-40R

DEAN R. GERIMONTE, D.C., *et al.*,

Plaintiffs,

v.

WASHINGTON CHIROPRACTORS ASSN., INC., *et al.*,

Defendants.

THIS MATTER comes before the Court on defendants' motion to dismiss the amended complaint (hereafter "complaint") on the ground that it is barred by the McCarran-Ferguson antitrust exemption. 15 U.S.C. §§ 1011-15.[1]

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[1] Section 2(b) of the McCarran-Ferguson Act (hereinafter referred to as the "McCarran Act"), 15 U.S.C. § 1012(b), provides in relevant part:

(Footnote continued on following page)

Order Granting Defendants' Motion to Dismiss

Plaintiffs are five chiropractors engaged in the private practice of chiropractic in Washington who challenged the peer review procedure utilized by health insurance carriers in conjunction with the Washington Chiropractors Association, Inc. (WCA). They allege that the defendants are engaged in a conspiracy and combination to fix prices and to boycott, coerce, and intimidate plaintiffs in an effort to monopolize the practice of chiropractic. Plaintiffs seek damages and injunctive relief pursuant to the Sherman and Clayton Acts.

The defendant insurers provide health insurance coverage to individuals and groups that include coverage for chiropractic services. The insurance contracts limit reimbursement to usual and customary charges for neces-

---

(Footnote continued from preceding page)

> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance: *Provided*, That the Sherman Act, . . . the Clayton Act, and . . . the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State Law. (Emphasis Added)

Section 3(b) of the McCarran Act, 15 U.S.C. § 1013(b), states in full:

> (b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, or intimidate, or act of boycott, coercion, or intimidation.

sary health care services rendered.[2] Defendant WCA, a professional organization, sponsors a Peer Review Committee that upon request by insurers examines claims submitted to the insurer to determine if the claim exceeds a reasonable, usual and customary charge for that service. The individual defendants are present or past members of the Peer Review Board of Directors and are individual members of that Committee, who have rendered decisions on individual claims submitted to them. The American Chiropractic Association and the individual members of the American Chiropractic Association's Insurance and Peer Review Committee are named as co-conspirators.

The plaintiffs allege that the WCA Peer Review Committee procedures just described result in a ceiling on the extent to which policyholders are reimbursed by insurance companies for fees charged to policyholders by chiropractors. According to plaintiffs, the insurers refuse to reimburse claims except within the alleged price ceiling. This, plaintiffs allege, results in refusal to deal with the service providers for those chiropractic services that are billed above the maximum fixed fee. They further claim that the result of this conspiracy is to coerce patients to seek treatment elsewhere and to coerce chiropractors themselves to adhere to the WCA fee schedule.

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[2] Aetna's accident and health insurance policies in the State of Washington provide that no coverage shall be afforded "for care, treatment, services or supplies which are not necessary for the treatment of the injury or disease" nor any other charges "to the extent that" such charges are "unreasonable." One form approved by the Insurance Commissioner defines a reasonable charge as "the prevailing charge made for a [service or supply,] in the geographic area, by those of similar profession or standing."

Order Granting Defendants' Motion to Dismiss

Plaintiffs' second count alleges that the peer review procedures have been implemented "to monopolize and exclude doctors of chiropractic" from "various markets" in the health care field. The monopolization and boycott claim is based on the refusal of insurers to reimburse policyholders for the cost of undergoing certain treatments, namely, "plethysmography" and "dopplar ultrasound", which are not recognized by the peer review committee as justifiable, or by the insurers as compensable under the terms of their policies.

Plaintiffs have also asserted ancillary state claims against the individual defendants and the WCA for interference with contractual relations and for libel and slander for which they seek compensatory and punitive damages. Defendants have moved to dismiss the state claims on the ground that the court will lack jurisdiction over those claims if their motion to dismiss is granted as to the federal antitrust claim.

Having reviewed the complaint and memoranda of counsel, the court grants defendants' motion for the reasons given below.

Under the McCarran-Ferguson Act, the Sherman and Clayton Acts are applicable to the business of insurance only "to the extent that such business is not regulated by state law."[3] State regulation may not, however, shield conduct which amounts to boycott, coercion or intimidation.

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[3] The parties apparently agree that defendants are regulated by the State, as contemplated in the McCarran Act's grant of antitrust immunity to insurance companies. The Court is satisfied that all aspects of the insurance industry are extensively regulated in the state of Washington.

But before the deference to state regulation comes into operation, the conduct must be found to be the "business of insurance." 7 Van Kalinowski, *Antitrust Laws & Trade Regulation* §§ 47.01-.03 (1978 ed.).

THE BUSINESS OF INSURANCE

The most recent Supreme Court case dealing with the McCarran Act exemption was *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.*, 440 U.S. 205 (1979). *Royal Drug* involved an antitrust challenge to defendant Blue Shield's alleged fixing of retail prices of drugs and pharmaceuticals through its "pharmacy agreements." The Supreme Court held that defendants did not come within the McCarran Act exemption because the pharmacy agreements were not the "business of insurance." The Supreme Court stated that "[t]he primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." *Id.* at 211. The pharmacy agreements were characterized by the Court as arrangements for Blue Shield's purchase of goods and services, and not as involving the underwriting or spreading of risks. *Id.* at 214. Another aspect of the business of insurance is the contract between the insurer and the insured. *Id.* at 215.

The Courts of Appeals for the Second and Fourth Circuits have faced the same issues before us now with all facts and allegations being directly on point. In *Bartholomew* v. *Virginia Chiropractors Association*, 612 F.2d 812 (4th Cir. 1979), *cert. denied*, 446 U.S. 38 (1980) the Court held that defendants were immune from antitrust liability under the McCarran Act because the peer review system was part of the business of insurance.

The Second Circuit in *Pireno* v. *New York State Chiropractic Association*, 650 F.2d 387 (2d Cir. 1981), *petition for cert. filed*, 50 U.S.L.W. 3150 (U.S. Sept. 28, 1981) (No. 81-389), specifically declining to follow *Bartholomew*, held that the peer review procedures were not the business of insurance. While the *Pireno* opinion offers a more detailed and careful analysis than the one in *Bartholomew*, this Court does not find it persuasive.

The peer review system serves to determine the extent of the insurers' contractual obligations to their policyholders. The insurance contracts limit reimbursement to usual, customary, and reasonable charges for necessary health care services rendered. The determination of usual and customary charges is done through the mechanism of the peer review committee. The interpretation of the terms of the policy, which will in turn determine the rights of the policyholder, is of direct and immediate concern to the insured. When Congress enacted the McCarran-Ferguson Act it was concerned with precisely this relationship between insurer and insured—the "core of the 'business of insurance.'" The focus of Congress was "on the relationship between the insurance company and the policyholder." *Royal Drug*, 440 U.S. at 215, *citing*, *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1968).

In *Royal Drug* Blue Shield entered into agreements with pharmacies obligating the pharmacists to provide drugs to Blue Shield policyholders at a fixed rate. The peer review system used by the insurance companies here merely establishes what the insurers will pay their policyholders under their contracts. The chiropractors are free to demand whatever fee they wish; no policyholder

is refused reimbursement for any fees of any chiropractor so long as the fees are usual and customary. The range of fees which are usual and customary is determined by the WCA. Unlike the situation in *Royal Drug*, the rates are not dictated by the insurers. If the usual and customary fees rise or if the usual and customary services offered by chiropractors expand, the insurance companies will necessarily reimburse their policyholders for those fees. The service provider agreements of *Royal Drug* simply are not present here. The freedom of chiropractors to impose higher fees and collect the difference from their patients, as plaintiffs have, in fact, done, demonstrates that insurer defendants have determined nothing other than the extent of their own contractual obligations to their policyholders. The peer review system fits squarely within the "traditional model" of the insurance contract.

The Supreme Court found Blue Shield's arrangement outside the business of insurance not only because "[t]he Pharmacy Agreements are not 'between insurer and insured,'" but also because the agreements did not involve any underwriting or spreading of risk. *Id.* at 216 and 214. The Court recognized that the pharmacy agreements resulted in cost savings to Blue Shield which might have been passed on to policyholders in lower premiums. Lower premiums might have an impact on Blue Shield's reliability, its ratemaking, and its status as a reliable insurer. Nevertheless, the pharmacy agreements were only cost reducing and not, in themselves, risk spreading. *Id.* at 214.

The case of *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, 406 F. Supp. 27 (D.D.C. 1975) is particularly helpful. Car repairmen brought an antitrust action against insurers and companies engaged in the business of

adjusting damage claims. The repairmen alleged a conspiracy to fix a ceiling on the amounts which the insurers would reimburse policyholders. As in the present case, the repairmen alleged that the insurers had entered into an agreement to reimburse their policyholders according to a formula which involved the "prevailing labor rate", a standardized estimate of the amount of labor required, and a compulsory discount on parts.

The district court determined that the challenged activity was part of the "business of insurance" because it involved the adjustment and settlement of claims. Claim settlement procedures, according to the court, concern payment to insureds, matters of policy interpretation and enforcement, and an insurer's rate-making structure. *Id.* at 29. Similarly, the claims-adjustment operation of the peer review committee is an integral part of the "business of insurance."[4]

THE ALLEGED BOYCOTT

Under the provisions of the McCarran Act, even if the activity in question is found to be the business of insurance it will not be exempt if it amounts to a boycott, coercion or intimidation. In the instant case, plaintiff chiropractors allege that the defendant chiropractors pressured plaintiffs to discontinue use of the disputed treat-

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[4] After the D.C. Circuit affirmed *Proctor*, 561 F.2d 262 (D.C. Cir. 1977), the Supreme Court vacated the decision for reconsideration in light of its decision in *Royal Drug*. 440 U.S. 942 (1979). Upon remand from the Court of Appeals, the District Court concluded that the opinion of the Appeals Court remained "undisturbed *in proprio vigore*". 1980-1 Trade Cas. (CCH) ¶63,591.

ments by enlisting the insurance companies to refuse to pay for such treatments. In turn, it is alleged, the insurers encouraged, even coerced and intimidated their insureds to withhold patronage from the target plaintiffs by threat of non-payment and by distribution of misleading and inaccurate information. As an example, plaintiffs point out that one of them was charged by the Washington Chiropractors Disciplinary Board (not the Peer Review Committee) with charging excessive or unreasonable professional fees.

In *St. Paul Fire and Marine Insurance Co.* v. *Barry*, 438 U.S. 531 (1978), the Supreme Court observed that, "whatever the precise reach of the terms 'boycott,' 'coercion,' and 'intimidation,' the decisions of this Court do not support the . . . suggestion that they are coextensive with the prohibitions of the Sherman Act." 438 U.S. at 545 n. 18. In response to a concern of Justice Stewart in his dissent, the Court stated that it was "cited to no decision in which price fixing, in the absence of any additional enforcement activity, has been treated as 'boycott' or 'coercion.'" *Id.* Justice Powell, writing for the majority, stated at least six times that the facts before the Court constituted a refusal to deal on *any terms*. *Id.* at 533, 535, 540, 544, 552, and 553.

The *Barry* opinion provides substantial support for the distinction between a concerted refusal to deal at all and a concerted refusal to deal except on particular terms. *See*, Carlson, *The Insurance Exemption from the Antitrust Laws*, 57 Texas L. Rev. 1127, 1169 (1979). According to this commentator, the *Barry* decision requires lower courts to apply vigorously the distinction between concerted refusals to deal at all and concerted refusals to deal except on particular terms, the distinction being necessary to pro-

tect state regulation of insurance. *Id.* at 1168. The commentator goes on to apply the distinction in light of the *Proctor* and *Bartholomew* cases, *supra*.

> [A]greements between insurance companies to adjust claims based on prevailing or customary prices should remain the business of insurance under *Royal Drug*, and tradesmen [or, as in this case, chiropractors] will undoubtedly continue to claim that these agreements constitute boycott, coercion, or intimidation.

Id. at 1172. The author agreed with the *Proctor* court that section 3(b) does not include an agreement between insurance companies concerning a formula for claims adjustment based on prevailing or customary prices:

> The claimants in *Proctor* were free to use their checks to patronize higher priced shops for any reason. . . . If the insurer does not penalize a claimant for patronizing a particular shop, the economic inducement not to patronize that shop will be measured by the difference between that shop's prices and the prevailing rate. Thus, any economic pressure not to patronize a higher priced shop is no greater than the coercion that the forces of the marketplace would otherwise exert absent an insurance mechanism. Indeed, a claimant may be more willing to patronize a higher priced shop when it costs him only a small out-of-pocket sum in addition to his insurance check than he would be if faced with the prospect of footing the entire bill.

Id. at 1173.[5] Similar reasoning was applied by the *Bartholomew* court. 612 F.2d at 817, 818.

The policies of all the defendant insurers contained a term restricting reimbursement to usual and customary rates. The claims settlement procedure which utilizes the peer review committee may well result in a maximum rate of reimbursement. Nevetheless, the same rate of reimbursement is offered *without discrimination to all providers* of insured services. That it may be insufficient to subsidize the higher fees charged by some providers, or to cover allegedly more extensive or sophisticated services which some producers choose to sell, does not transform the agreement into a boycott. Of course, the Court is not deciding whether the peer review procedures result in actual price fixing, but certainly this Court agrees with the Court of Appeals in *Proctor* that the procedure in question does not have the degree of coercive enforcement activity which would make it a boycott.

INDIVIDUAL DEFENDANTS

The McCarran-Ferguson Act exempts the chiropractor-defendants as well as the insurer-defendants with respect to allegations arising from their participation in peer review. Defining the exemption to cover the insurer defendants while leaving peer review defendants exposed to fed-

[5] The petition for certiorari in *Proctor* raised the question of whether the conduct involved was within the business of insurance and not whether the Court of Appeals erred in finding that no boycott had been disclosed. The District Court wrote on remand that the Court of Appeals holding on the boycott issue remained undisturbed. 1981-1 (CCH) Trade Cas. at 77,140.

eral antitrust actions would, as a practical matter, have the same debilitating effect on the peer review process as if there were no exemptions at all. It is doubtful that service providers would continue to volunteer for peer review activities if persons whose fees are reviewed could retaliate with an antitrust action. Without such volunteers, the right of insurance companies to use outside advisors would be an empty one. *Cf., Lowe* v. *Aarco-American, Inc.,* 536 F.2d 1160 (7th Cir. 1976).

IT IS THEREFORE ORDERED that the plaintiffs' complaint be dismissed.

The clerk of this court is directed to send uncertified copies of this order to all counsel of record.

DATED at Seattle, Washington, this 16th day of October, 1981.

BARBARA J. ROTHSTEIN
United States District Judge

Amicus Brief

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Nos. 81-389, 81-390

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY,
Petitioner,

—v.—

A. ALEXANDER PIRENO,
Respondent.

NEW YORK STATE CHIROPRACTIC ASSOCIATION,
Petitioner,

—v.—

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BRIEF OF AMICI CURIAE IN SUPPORT OF PETITIONS FOR CERTIORARI

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BRIEF OF AMICI CURIAE IN SUPPORT OF PETITIONS FOR CERTIORARI

The Health Insurance Association of America ("HIAA") is a trade association consisting of 300 commercial insurers, which account for over 80% of the health insurance written by such companies in the United States. The American Council of Life Insurance ("ACLI") is comprised of over 500 life insurance companies, most of which write health as well as life insurance and are also members of HIAA.

Pursuant to Rule 36 of the Rules of this Court and with the consent of all parties, HIAA and ACLI respectfully file this brief *amici curiae* in support of the petitions for a writ of

certiorari which seek review of the Second Circuit's decision holding that peer review procedures used by health insurers to evaluate claims under their insurance contracts are not the "business of insurance" exempted from the federal antitrust laws by the McCarran-Ferguson Act, U.S.C. §§ 1011-1015.

Statement of Interest of Amici

The petitions raise two questions of great importance to the members of HIAA and ACLI. First, the petitions seek resolution of a conflict between the Second and Fourth Circuits which creates confusion as to whether peer review procedures are shielded from the risks and burdens of antitrust litigation by the McCarran-Ferguson exemption. *Amici* concur in petitioners' view that, if left unreviewed, the decision below will chill the use of peer review, a procedure of great importance to the fair, effective and economic administration of health insurance contracts.

Second, and of even broader significance, the petitions seek review of the Second Circuit's conclusion that in *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.*, 440 U.S. 205 (1969) ("Royal Drug"), this Court abandoned the teachings of *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969) ("National Securities"), in favor of a definition of the "business of insurance" so narrow that it would exclude from the McCarran-Ferguson exemption the entire claims settlement process, heretofore commonly understood to be within the "core" of the business of insurance. *Amici* also concur in petitioners' view that, if left unreviewed, this aspect of the Second Circuit's decision will generate confusion about the scope and continued significance of the McCarran-Ferguson exemption.

The interest of *amici* in these issues is clear. Their member companies, in the conduct of their health insurance business, are regularly called upon to review claims for reimbursement, and to determine the extent to which they are obligated by their

contracts of insurance to honor these claims. Peer review is a part of that process.

The review procedure at issue in this case is typical of procedures used by health insurers throughout the country. All of the peer review committees provide a similar service for the insurer: informed and impartial advice as to whether an insured's claim for reimbursement reflects only the "usual and customary" charges for "necessary" health care services covered by insurance, or whether portions of the insured's medical bill reflect unnecessary or inflated charges that exceed the insurer's obligation to pay.

There are hundreds of peer review committees throughout the nation rendering such advice. HIAA conservatively estimates that its members refer more than 10,000 claims to these committees per year.

HIAA gathers for its members extensive information on the availability of peer review committees for particular health care fields and localities, and also monitors the effectiveness of the peer review procedure. HIAA has found that peer review is an important aspect of the fair administration of the business of health insurance, and is an important device which helps minimize the inflationary impact of insurance on health care costs.

Amici and their members are, therefore, directly affected by the impact of the Second Circuit's decision on the continued availability of peer review.

Beyond that, however, ACLI and HIAA have a broader reason for seeking review of the Second Circuit decision. That decision threatens to remove from the McCarran-Ferguson exemption a host of activities until now thought to be the exclusive concern of state insurance regulation. The novel suggestion made by the Second Circuit, that claims settlement procedures may not be a part of the "business of insurance," is startling to *amici* and to insurers. The experience of *amici*

indicates that the policy of the Act, as previously explained in *National Securities*, remains sound and enables the insurance industry to conduct its business responsibly: regulation of activities such as those involving the interpretation of insurance policies and the payment of claims should be the primary responsibility of the states, through their legislatures and insurance departments, rather than of the federal judiciary, through the vehicle of antitrust suits. Furthermore, if that policy is to be changed, it should certainly not be by the unreviewed decision of a lower court.

In sum, *amici* support the petitions for review of the decision below because it threatens both a practice deemed essential to the health insurance industry and the continued applicability of the McCarran-Ferguson Act to activities long understood to be the essence of the "business of insurance."

Statement of the Case

As explained in the petitions of the Union Labor Life Insurance Company ("ULL") and the New York State Chiropractic Association ("NYSCA"), the issue in this case is whether the "business of insurance" under the McCarran-Ferguson Act includes a practice used by health insurers for determination of the coverage limits of most of their policies. Although specific wording varies, the typical policy at issue here obligates the insurer to pay "usual, customary and reasonable" ("UCR") fees for "necessary" medical services. Where it appears that a claim may be excessive, the companies sometimes ask the advice of a peer review committee composed of professionals in the appropriate community and health care field. The committee then renders its opinion, which the insurance company is free to use as the basis of its own determination as to whether the terms of the UCR policy are met.

In short, peer review provides a fair and accurate method for determining whether a claim fits within the terms of a UCR

policy. The District Court, in an "especially clarifying discourse" adopted by the Fourth Circuit in *Bartholomew* v. *Virginia Chiropractors Ass'n*, 612 F.2d 812, 817 (1979), *cert. denied*, 446 U.S. 938 (1980), therefore held that the peer review practice challenged here fit within the core of the "business of insurance" as defined by the *National Securities* and *Royal Drug* cases. This holding was overturned by the Second Circuit in the decision of which review is now sought.

SUMMARY OF ARGUMENT

We agree with the ULL petition that the Second Circuit decision is erroneous because:

(1) It proceeds from an unduly narrow conception of the scope of the McCarran-Ferguson Act, disregarding the principle stated in *National Securities* and reaffirmed in *Royal Drug* that the relationship between insurer and insured and the interpretation and enforcement of the policy are at "the core of the 'business of insurance.' " ULL Petition at 13-17.

(2) It draws a meaningless distinction between activities that are part of "the underwriting or spreading of risk," *Royal Drug*, 440 U.S. at 213, and activities that "determine whether . . . the risk has been transferred," Apdx. 15a.* In fact, peer review is an integral part of the risk-spreading process precisely because, by making concrete and helping to apply the flexible terms of the UCR policy, it helps determine the scope of the risk covered by the policy. ULL Petition at 17-18.

(3) It concludes incorrectly that peer review is outside the "business of insurance" because it is "merely a form of cost reduction," Apdx. 15a. In fact, cost limitation is but one aim of peer review, which in some cases may actually cause insurers to pay claims that otherwise they would reject. Peer review is necessary not to contain costs, but rather to contain costs *fairly* within the terms of the policy. ULL Petition at 18-20; *see* pp.

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* "Apdx." refers to the Appendix to the ULL petition.

10-11 *infra*. Nothing in *Royal Drug* suggests that a procedure such as peer review is out of the "business of insurance" merely because, by helping insurers make more informed interpretation of policy limits, it also helps minimize reimbursement of excessive or unreasonable charges.

(4) It makes the suggestion, startling to those in the industry, that claims settlement may not be part of the "business of insurance." Apdx. 18a.

We wish to supplement these points by presenting, from the perspective of *amici*, two basic reasons why it is important that this Court review the Second Circuit's decision. In short, we believe not only that the decision is erroneous but also that it has great significance (a) in particular, for the availability of peer review, an important practice in insurance administration, and (b) in general, for the interpretation of the McCarran-Ferguson Act.

ARGUMENT

I

THE SECOND CIRCUIT DECISION CASTS DOUBT ON THE LEGAL STATUS OF A PRACTICE THAT IS IMPORTANT TO SOUND ADMINISTRATION OF HEALTH INSURANCE

The Second and Fourth Circuits are in direct conflict concerning the legal status of insurers' use of peer review for enforcement of policy terms. This Court should resolve the conflict because peer review, which is used thousands of times per year by insurers, is an important practice for the sound administration of health insurance. Insurers' use of peer review serves three interrelated purposes. All three affect "[t]he relationship between insurer and insured," and all three are in the public interest.

First, and by far the most important, peer review provides insurers with informed, broad-based advice in interpreting the

risk limits of their policies. This is necessary because the payment required by a UCR policy depends upon whether a health care service was necessary and whether the fee paid for it was reasonable.

The flexibility of the UCR policy explains why in the last two decades it has become "the most commonly used method of insurance reimbursement for physicians' fees," replacing the old "fee schedule" policies that expressed coverage limits in terms of fixed dollar amounts for various treatments. Z. Dyckman, *A Study of Physicians' Fees* 27 (1978) (Staff Report prepared by the Council on Wage and Price Stabilization). But the same flexibility means that there will often be questions, requiring professional advice to resolve fairly, as to whether a claim comes within the bounds of the policy's coverage.

Peer review is the best method by which insurers can secure that advice. Most insurers could not feasibly hire several qualified professionals in each of a wide variety of medical specialties. Moreover, the UCR policy requires an insurer to assess a claim in the context of the medical practice and the range of fees prevailing in a particular community, a subject on which insurance companies plainly cannot have adequate expertise without outside assistance. Indeed, HIAA publishes for its members a *Manual of Review Committees* simply so the companies will know of the existence and availability of peer review committees in each specialty and community.

The importance of peer review in assisting sound administration of the UCR policy is highlighted by the fact that until chiropractic peer review became available insurers were reluctant, for want of an accurate claims review procedure, to provide chiropractic coverage under a UCR policy. *See* NYSCA petition at 4-5.

The second purpose served by insurers' use of peer review is that it provides an impartial mechanism for resolution of policy disputes short of litigation. Indeed, HIAA believes that the benefits of peer review extend far beyond the cases in which the procedure is actually invoked; the very availability

of peer review is likely to give insureds confidence that their policies will be fairly administered and will protect them against risk.

The third purpose served by peer review is containment of the costs of insurance settlements. But peer review is not necessary simply to limit the aggregate amount of settlements paid; even an arbitrary system of claims review, devoid of professional expertise, could do that. Rather, peer review provides the *fairest* method of cost containment, sifting out those claims that are truly excessive and so do not come within the terms of the policy. Furthermore, as ULL's petition, at 20, points out, in some cases peer review, far from reducing costs, provides the basis for an insurer to pay a claim that otherwise it would have regarded as excessive.

Peer review's cost containment function does not, of course, resemble that of the provider agreements in *Royal Drug*, which sought to lower the prices of the drugs that the insurer was obligated to furnish to its insureds. Rather, peer review contains insurance costs not by fixing the price of any goods or services but by enabling an insurer to assess more accurately whether a claim falls outside the policy limits because the doctor charged his patient an unreasonable fee or performed an unnecessary service. This is necessary because a patient has little incentive to resist a higher fee if a third party has promised to pay the cost of a medical service; under a flexible-payment policy such as the UCR, therefore, ordinary market restraints have limited impact. *See, e.g.*, Enthoven, *Rx for Health Care Economics: Competition, Not Rigid NHI*, 59 Hospital Progress, 44, 44 (1978); Havighurst, *Controlling Health Care Costs*, 1 J. Health Politics, Policy & Law 474 (1977); S. Rep. No. 93-1285, 93d Cong., 2d Sess. at 39 ("the health care industry does not respond to classic marketplace forces").

In short, the cost-containment function of peer review is made necessary by the nature of the insurance contract. Peer review is the soundest way of assuring that the UCR policy

truly covers only reasonable fees and is not misused as a device to subsidize runaway charges.

For these reasons, peer review has been widely recognized to be in the public interest. In its 1967 Report, at 48, the National Advisory Commission on Health Manpower recommended that "professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care." Drawing on this report, Congress has made peer review an integral part of the Medicare, Medicaid, and Maternal and Child Health Programs. *See* 42 U.S.C. § 1320c *et seq*.

Because health care professionals are unlikely to volunteer their services to peer review committees if exposed to antitrust litigation, the Second Circuit decision threatens the continued availability of this practice so important to the administration of health insurance. That decision, in conflict with the Fourth Circuit, should not be allowed to stand unreviewed.

II

THE SECOND CIRCUIT DECISION HAS BROAD SIGNIFICANCE FOR INTERPRETATION OF THE McCARRAN-FERGUSON ACT

A. Background of the Act.

The Second Circuit suggested, Apdx. 17a, that this Court did not mean what it appeared to say in *National Securities*, 393 U.S. at 460, and reaffirm in *Royal Drug*, 440 U.S. at 215-16, that "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation and enforcement" are the core of the "business of insurance." The Second Circuit's abstract discussion of the term "business of insurance" does not take into account the policy of the McCarran-Ferguson Act, a policy that is clearly demonstrated by the Act's well-known history.

"The McCarran-Ferguson Act was passed in reaction to this Court's decision in *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944)." *National Securities*, 393 U.S. at 458. That case, which held for the first time that insurance transactions were subject to federal regulation under the Commerce Clause, and in particular to the antitrust laws, aroused concern that it would create "inroads . . . on the tradition of state regulation of insurance. The McCarran-Ferguson Act was the product of this concern." *Id.* Given the "overwhelming endorsement of the principal national organizations of State insurance commissioners, insurance executives, agents, brokers and underwriters," S. Rep. No. 20, 79th Cong., 1st Sess. 3 (1945); H.R. Rep. No., 143, 79th Cong., 1st Sess. 7 (1945), the Act provided *inter alia* that the federal antitrust laws would be applicable to the "business of insurance" after June 30, 1948 only "to the extent that such business is not regulated by State law." § 2(b), 15 U.S.C. 1012(b).

This historical context makes it clear that Congress did not intend to ascribe a technical or restrictive meaning to the term "business of insurance," which it did not define or analyze. Rather, the scope of the Act was as broad as the "free hand" that the States had had before *South-Eastern Underwriters* "in regulating the dealings between insurers and their policyholders"; that is, the Act was intended "to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation." *National Securities*, 393 U.S. at 459.

Ratemaking activities were a primary focus of Congressional concern, because they had been at issue in *South-Eastern Underwriters*, *see National Securities*, 393 U.S. at 459-60. But obviously ratemaking did not measure the scope of the statute. The Act used the broad term "business of insurance" and has been held to embrace such various activities as "[t]he selling and advertising of policies, *FTC* v. *National Casualty Co.*, 357 U.S. 560 (1958), and the licensing of companies and their agents, *cf. Robertson* v. *California*, 328 U.S. 440 (1946)." *National Securities*, 393 U.S. at 460.

These principles should have determined the outcome of this case, for as the Second Circuit acknowledged, peer review "performs an 'adjusting' function commonly performed by insurance company personnel," Apdx. 18a; *see* C. Cissley, *Claim Administration: Principles and Practices* 202-03 (1980) (discussing peer review as part of the claims settlement process). The Second Circuit, however, adopted a theory that would exclude from the McCarran-Ferguson Act not only the peer review procedure at issue here but virtually every other practice commonly understood to be part of the "business of insurance." This is a result of the Second Circuit's unduly narrow and hypertechnical reading of language from *Royal Drug* and its disregard of *National Securities*.

Referring to this Court's statement in *Royal Drug*, 440 U.S. at 213, that "the underwriting or spreading of risk is a critical determinant in identifying insurance," the Second Circuit conceded that "an activity or procedure that does not either transfer risk from insured to insurer or spread the risk among insureds is not the business of insurance." Apdx. 14a. The Second Circuit applied this conclusion in an extraordinarily narrow way, stating that peer review has no role in the spreading of risk, Apdx. 14a, and declaring:

> "Peer review takes place only after the risk has been transferred by means by the policy, and . . . is thus not a means of transferring risk from insured to insurer. At most, it is an aid in determining the scope of the transfer after it has been made."

Apdx. 15a.

If this unrealistic distinction were consistently applied, even the collection of statistics necessary for ratemaking would not be held a "means of transferring risk," because no risk is actually spread or transferred by the mere act of collecting data. Rather, that act would be considered "[a]t most . . . an aid in determining the [price] of the transfer [before] it has been made"—and *not* a part of the "business of insurance." Indeed, the only activity that would be the "business of

insurance" would be the actual delivery of the policy from the carrier to the insured, for it is only by that act that the risk is actually transferred or spread.

The Second Circuit's error, of course, lay in its failure to recognize that, because peer review aids in determining the scope of the transfer of risk from insured to insurer, it helps define the "relationship between insured and insurer," and assists the interpretation and enforcement of the policy, *National Securities*, 393 U.S. at 460; it is therefore a "link in the process of insurance," C. Cissley, *Claim Administration*, *supra*, at iii, by which insurers effectuate the "underwriting or spreading of risk."

B. Claims Settlement.

One particularly striking result of the Second Circuit's restrictive interpretation of *Royal Drug* is its suggestion, Apdx. 18a, that claims settlement and adjustment may not fall within the Act. As stated in the ULL petition at 20-21, this is a shocking idea, especially since these practices are an important focus of state insurance regulation. In settling and paying a claim, the insurer is fulfilling its primary obligation under the policy; it is hard to name a practice that has a more direct bearing on "[t]he relation between insurer and insured." As a leading authority has stated:

> "Claim administration is the last link in the process of insurance . . . [T]he expectation of the policyowner that an insurer is willing to meet its obligations, through claim administration, is an important part in the decision to purchase insurance. Indeed, it is the claim administration function that delivers on the product sold to the policyowner."

C. Cissley, *Claim Administration*, *supra*, at iii.

Moreover, if the Second Circuit decision were to stand, it might open to antitrust challenge various claim-related activi-

ties in which insurance companies participate jointly, such as the following:

(1) The activities of the International Claim Association ("ICA") which seeks "[t]o promote efficiency, effectiveness and high standards of performance in claim administration." ICA Constitution, Art. II, § 1.

(2) HIAA's collection from its members of data showing the range of fees charged for various medical services in localities throughout the United States, and publication of this data for the use of its members. *E.g.*, HIAA, *Surgical Prevailing Healthcare Charges System* (1981). Insurance companies use these data to assist them in making a preliminary assessment of the reasonableness of a claim. One of Congress' primary concerns in passing the Act was its recognition of "the necessity for concert of action in the collection of statistical data and rate making." *Royal Drug*, 440 U.S. at 221-22, *quoting* report of National Association of Insurance Commissioners (emphasis deleted). That concern is as substantial whether the cooperative collection of data is used to set rates accurately or to assess claims accurately—especially since the statistical prediction of claims is a primary determinant of rates.

(3) Detection of fraudulent claims by use of information gathered from and made available to insurers by the Medical Insurance Bureau ("MIB"). Life insurance companies can learn from MIB, for example, whether a policyholder failed to disclose on his application a pre-existing medical impairment.

(4) Use by more than one insurer, where they cover the same risk, of the same claims report prepared by an independent claims agency, such as Equifax Services, Inc. These agencies are frequently used where it would be expensive or impractical for company personnel to investigate and report.

C. Industry Personnel.

The Second Circuit also suggested that the peer review procedure, although part of the claims settlement process, is not within the "business of insurance" because "the peer review committee is not a member of the insurance industry. [T]he antitrust exemption seeks primarily to shield agreements among insurers, not those between insurers and persons outside the industry." Apdx. 18a.

In reaching this conclusion, the Second Circuit misapplied a statement in *Royal Drug* suggesting that an alternative ground for holding the provider agreements beyond the "business of insurance" might be that they were not "wholly intra-industry"; the agreements were made with pharmacists for the purchase of pharmaceutical "goods and services." 440 U.S. at 225 n.32.

The *Royal Drug* agreements extended beyond the insurance industry because they did not call for the provision of insurance services, not because of a talismanic label that might be applied to the participants. The agreements sought to determine the prices charged by druggists for their goods and services.

The peer review procedure here, by contrast, is an insurance activity because its only function is to render advice on the application of an insurance contract. While the committee members are chiropractors, peer review does not call upon the committee to render any chiropractic service to the insured or to the insurer. The facts that the committee's members are not on the payroll of an insurance company and that they may practice chiropractic when they are not serving on the committee do not alter the character of the committee's advisory service.

Thus, to exclude the peer review procedure challenged here from the "business of insurance" would abandon the principle of *National Securities* that the McCarran-Ferguson Act "refers not to the persons or companies who are subject to state

regulation, but to laws regulating the *business* of insurance' ". 393 U.S. at 459 (emphasis in *National Securities*). Nothing in *Royal Drug* suggests that the Court intended this result.

CONCLUSION

Peer review is an important practice for the sound administration of health insurance. The McCarran-Ferguson Act continues to represent an important Congressional decision that the "business of insurance" should be the concern of state insurance laws, not of the federal antitrust laws. This Court should not allow the unreviewed decision of the Second Circuit, in conflict with that of the Fourth Circuit, to threaten the continued vitality of peer review and of the Act.

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Petitioner's Brief

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Nos. 81-389 and 81-390

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

No. 81-389

UNION LABOR LIFE INSURANCE COMPANY,
Petitioner,

—v.—

A. ALEXANDER PIRENO,
Respondent.

No. 81-390

NEW YORK STATE CHIROPRACTIC ASSOCIATION,
Petitioner,

—v.—

A. ALEXANDER PIRENO,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE PETITIONER NEW YORK STATE CHIROPRACTIC ASSOCIATION

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Questions Presented

I. Whether the federal antitrust exemption provided by the McCarran-Ferguson Act for the business of insurance applies to the widespread use of peer review by which health insurers solicit advice from health care professionals as to the reasonableness or propriety of certain reimbursement claims under health insurance policies.

II. Whether, as suggested by the United States Court of Appeals for the Second Circuit, this Court has recently abandoned altogether its previous definition of the business of insurance under the McCarran-Ferguson Act in favor of a much narrower definition which excludes activities involving the interpretation and enforcement of the insurance policy, heretofore considered the "core of the business of insurance."

Parties to the Proceeding Below

In the appeal to the Second Circuit, the respondent, A. Alexander Pireno, was the plaintiff-appellant. The petitioner, the New York State Chiropractic Association, and the Union Labor Life Insurance Company, were defendants-appellees. The Union Labor Life Insurance Company is simultaneously filing a separate brief.

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IN THE

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OCTOBER TERM, 1981

Nos. 81-389 and 81-390

No. 81-339

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Respondent.

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Petitioner,

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A. ALEXANDER PIRENO,
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ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE PETITIONER NEW YORK STATE CHIROPRACTIC ASSOCIATION

Petitioner New York State Chiropractic Association ("NYSCA") prays that the judgment of the Second Circuit Court of Appeals be reversed, and that the judgment of the District Court for the Southern District of New York be reinstated.

Petitioner NYSCA joins with and supports the brief filed by Union Labor Life Insurance Company in this action. The NYSCA brief will supplement the one filed by Union Labor Life Insurance Company.

Opinions Below

The opinion of the United States Court of Appeals for the Second Circuit (App. A)[1] is officially reported at 650 F.2d 387. The opinion of the United States District Court for the Southern District of New York (App. B) is reported at 1979-2 Trade Cases (CCH) ¶ 62,758.

Jurisdiction

The judgment of the United States Court of Appeals for the Second Circuit (App. A) was entered on May 28, 1981. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

Statute Involved

Petitioner seeks immunity from the respondent's antitrust action under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (App. D), which exempts from the federal antitrust laws activities that: (i) constitute the business of insurance; (ii) are regulated by state law; and (iii) do not involve boycott, coercion or intimidation.

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1 Parenthetical references preceded by "App." refer to the Appendix to Petitioner Union Labor Life Insurance Company's Petition for a Writ of Certiorari.

Statement of the Case

The NYSCA is a New York not-for-profit corporation formed in 1970 as a professional association for chiropractors.

In the early 1970's, New York chiropractors became aware that many of their patients' insurance claims for chiropractic services were being denied by the carriers. The companies' unfamiliarity with the practice of chiropractic meant that the companies often could not distinguish a valid claim from an unjustified claim, and many valid claims were denied. The typical insurance policy limits payment to "reasonable charges for necessary medical care and services" or to "regular and customary charges." The companies had need, therefore, of consultation with chiropractors to interpret these provisions of their contracts.

In order to assist insurance companies in providing coverage of chiropractic services, NYSCA formed a Peer Review Committee, and offered the services of the Committee to many insurance carriers. This service of the Committee was initiated, therefore, in response to a need by the insurance industry (App. A at 4a).

Carriers usually request peer review of a particular chiropractic claim after making an initial judgment that the service was unnecessary or that the claim is excessive and out of line with their experience for chiropractic claims for similar services (App. B at 23a). When a request is made, it is accompanied by a file of information which has been submitted to the carrier in support of the claim. The Committee then may request additional information from the treating chiropractor (App. B at 24a). The chiropractor is provided with the opportunity to appear before the Committee when the claim is considered (R.36, Davis Affidavit, Ex. G at 4).[2]

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2 Parenthetical references preceded by "R." refer to the document number of the Index to the Record on Appeal to the Second Circuit.

The Committee sends its opinion only to the carrier requesting review and to the treating chiropractor. In reaching an opinion, the Committee uses the collective judgment and experience of all of the Committee members, and takes into consideration a number of factors including the experience and overhead of the chiropractor, the nature of the treatment rendered, and the condition of the patient before and after treatment (App. A at 4a).

The opinion of the Committee is not binding on any party (App. A at 4a). The chiropractor retains his right to payment in full from his patient. Indeed, it is the prevalent practice of Respondent Pireno and most other chiropractors to be paid in full by the patient at the time of treatment (R.36, Davis Affidavit at 11). If the patient is reimbursed by his carrier less than the full amount paid, the patient remains free to claim against his carrier under his policy for the entire amount paid to the treating chiropractor. Further, the insurance carrier also is free to disregard the opinion of the Committee, and does so (App. B at 24a-25a). The Committee's decisions, therefore, are completely advisory.

This non-binding advisory characteristic of the Peer Review Committee's opinions (the same quality which NYSCA believes avoids any antitrust offense) guarantees their widespread use by the insurance industry. The insured patients, the treating chiropractors and, in particular, the carriers all look upon the opinions as a valuable and unique source of non-coercive expertise. If the peer review procedure were binding on the parties, they would be less likely to use it or to accept the results. It is one of the least objectionable of several possible claims settlement approaches in the view of insureds and chiropractors.

Thus, this non-coercive quality combined with the fact that it is a source of professional expertise impossible for the carriers to duplicate, makes the peer review procedure an irreplaceable element of the carriers' claims settlement process. The carriers need and rely on the Peer Review Committee's expertise and credibility. The Committee, in turn, performs the

peer review function at issue in this litigation solely at the request of insurance carriers (J.A. at 7a-8a).[3] If those requests ceased, that function would end.

Argument

I.

Peer Review Performed at the Request of Carriers and Which is a Necessary Part of Carriers' Claims Settlement is Part of the Business of Insurance.

The Peer Review Committee of NYSCA is a distinct, autonomous committee, with its own rules and procedural guidelines and its own membership qualifications and members. While review of excessive fees at the request of patients as well as consideration of ethical and other patient claims against chiropractors has always been a Peer Review Committee or an NYSCA function (R.36, Davis Affidavit, Ex. C at 1), that function is not challenged in this case. The only Committee function challenged is the review of insurance claims at the request of carriers (J.A. at 7a-8a).

This is the very function that was started by NYSCA solely to meet the needs of the insurance industry. This function of the Peer Review Committee is continued because the carriers continue to call upon it and maintain that it is an inimitable element of their claims settlement process.

NYSCA does not suggest that the McCarran-Ferguson exemption should apply to any other activity of the NYSCA or even any other activity of the Peer Review Committee other than that at issue in this case. Thus, for example, NYSCA does not contend that the exemption would shield the promulgation by NYSCA or the Peer Review Committee, of a fee schedule for use by its members.

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3 Parenthetical references preceded by "J.A." refer to the Joint Appendix submitted to the Supreme Court.

Therefore, NYSCA submits that, insofar as the Peer Review Committee participates in the process of "interpretation" and "enforcement" of the insurance policy by responding to requests for advice from an insurance company as part of claims settlement, its acts are exempt from the antitrust laws as part of the "business of insurance" under this Court's decisions in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) and *Securities and Exch. Comm'n v. National Securities, Inc.*, 393 U.S. 453 (1968).

II.

The Decision of the Second Circuit Adversely Affects a Function of Insurance Companies and Professional Societies Which is of Great Importance and Benefit to the Public.

Although the chance of finding an antitrust offense in peer review is probably remote, the expense of defending an antitrust action is far beyond the modest means of most professional societies. Certainly this is the case with NYSCA. The dues which build the treasury of the NYSCA are earmarked chiefly for educational activities and public service purposes. The NYSCA literally could be put out of business by a very few such antitrust attacks on the peer review procedure.

Therefore, no professional society or group of professionals otherwise willing to perform the public service of voluntary peer view of fees would dare to do so without the protection of the McCarran Act exemption. The risk of exposure to numerous antitrust actions by providers who are adversely affected by peer review decisions would be too great.

Alternatives to peer review include a fixed fee schedule to be made a part of the insurance contract. However, such a fee schedule is in fact impossible to construct properly without resort to professional participation. Chiropractors also would need to be involved in keeping it current. Thus, the degree of involvement ultimately could parallel that in peer review, but

without the much greater capability of peer review to deal with the great variety of claims presented to the carriers. Furthermore, even if a fee schedule were incorporated in insurance contracts, resort by the insurance company to a peer review committee would remain vital to determine the medical necessity of procedures performed. This, in fact, is now the reason for many of the peer review requests by insurance companies.

Clearly, then, there is no viable alternative to peer review that will enable insurance companies to effectively prevent claims outside the policy terms from being paid. Therefore, NYSCA submits that it is necessary to apply the McCarran-Ferguson shield to this activity, in order to ensure voluntary participation in the peer review process by an adequate number of professionals.

CONCLUSION

Because the peer review practice at issue in this action was created and exists solely to serve insurance companies in the performance of their claims settlement procedures, it should be considered an integral part of those procedures which themselves certainly are the business of insurance. Moreover, failure to include the Peer Review Committee's performance of its facet of insurance claims settlement under the McCarran Act protective exemption would dramatize for all professionals the spectre of antitrust exposure and certainly result in their refusal to further participate in this voluntary activity.

For the above reasons, the decision of the United States Court of Appeals for the Second Circuit should be reversed.

Respectfully submitted,

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Petitioner's Brief

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Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONER UNION LABOR LIFE INSURANCE COMPANY

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QUESTIONS PRESENTED

1. Whether the federal antitrust exemption provided by the McCarran-Ferguson Act for the "business of insurance" applies to peer review whereby a health insurer solicits advice from a committee of medical professionals of a state chiropractic association concerning whether certain chiropractic treatments were necessary or appropriate or whether certain fees were reasonable or customary so as to come within the express coverage limits of the insurer's policies.

2. Whether, as suggested by the decision below, this Court recently has abandoned altogether its previous definition of the "business of insurance" under the McCarran-Ferguson Act in favor of a much narrower definition which excludes activities involving the interpretation and enforcement of the insurance policy, heretofore considered the "core" of the "business of insurance."

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BRIEF FOR PETITIONER UNION LABOR LIFE INSURANCE COMPANY

Petitioner respectfully prays that the judgment of the United States Court of Appeals for the Second Circuit entered on May 28, 1981 be reversed and the judgment of the United States District Court for the Southern District of New York entered on March 19, 1979 be directed to be reinstated.

OPINIONS AND JUDGMENTS BELOW

The opinion of the Court of Appeals for the Second Circuit (App. A)[1] is reported at 650 F.2d 387. The judgment of the Second Circuit appears at Appendix C of the Petition for a Writ of Certiorari. The opinion of the District Court for the Southern District of New York (App. B) is reported at 1979-2 Trade Cas. (CCH) ¶ 62,758. The judgment of the District Court appears as Document Number 53 of the Index to the Record on Appeal to the Second Circuit.

JURISDICTION

The judgment of the Court of Appeals for the Second Circuit was entered on May 28, 1981. The Petitions for a Writ of Certiorari to the Second Circuit were filed on August 26, 1981. The petitions were granted on November 16, 1981. (J.A. 27a, 28a).[2] The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Petitioner seeks the immunity from the respondent's antitrust action provided by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15 (App. D), which exempts from the federal antitrust laws activities that: (i) constitute the business of insurance; (ii) are regulated by state law; and (iii) do not involve boycott, coercion or intimidation.

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1 Parenthetical references preceded by "App." refer to the Appendices to the Petition for a Writ of Certiorari.

2 Parenthetical references preceded by "J.A." refer to the Joint Appendix filed by petitioners with this Court.

STATEMENT OF THE CASE

The Parties

Petitioner, Union Labor Life Insurance Company ("ULL"),[3] is an insurer organized under the laws of Maryland and licensed in 44 states including New York. (J.A. 5a, 17a). As a licensed accident and health insurer in New York, where the events complained of took place (1979-2 Trade Cas. [CCH] at 78,377, App. B at 31a), ULL's activities are extensively regulated under the provisions of the New York Insurance Law (*see* arts. IV, VII, VII-A, IX-A, IX-D [McKinney 1966 & Supp. 1981]) and the regulations promulgated thereunder by the Superintendent of Insurance of the State of New York ("the Superintendent"). (State of New York, *Official Compilation of Codes, Rules and Regulations* tit. 11). The regulation applies, among other things, to the form and wording of ULL's insurance policies and its premium charges, loss ratio and claim settlement practices.

The New York State Chiropractic Association ("NYSCA") is a nonprofit New York corporation functioning as a professional association for chiropractors. NYSCA provides the peer review committee from which ULL solicits advice regarding difficult claims for reimbursement for chiropractic treatment. Members voluntarily serve without compensation on the peer review committee. (R. 36, Davis Affidavit, Exs. A, F, G; R. 38, Davis Deposition at 18; 1979-2 Trade Cas. [CCH] at 78,374, App. B at 22a).[4]

Respondent, A. Alexander Pireno ("Pireno"), is a chiropractor licensed and practicing in New York. Questions regarding the necessity or propriety of treatments rendered by Pireno

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3 Petitioner, Union Labor Life Insurance Company, has no parent company and no subsidiaries other than one which is wholly-owned.

4 Parenthetical references preceded by "R." refer to the document number of the Index to the Record on Appeal to the Second Circuit.

to policyholders or the fees charged for such treatments were considered on at least four occasions by the NYSCA peer review committee. (R. 36, Davis Affidavit, Ex. N; 1979-2 Trade Cas. [CCH] at 78,375, App. B at 25a).

Petitioner's Use of Peer Review

The New York Insurance Law requires accident and health insurers to reimburse insureds for chiropractic as well as other medical treatment. (N.Y. Ins. Law § 221[5][e] [McKinney Supp. 1981]). The medical treatment provided under certain ULL policies,[5] which are approved by the Superintendent, include the following specific limitations of coverage: (1) the treatment must be within the scope of the doctor's license to practice; (2) the treatment must be for accidental injury or sickness unrelated to the occupation of the insured; (3) reimbursement under the major medical and supplemental coverages is limited to "the reasonable charges . . . for necessary medical care and services" and the "regular and customary charges for the services and treatment furnished." (J.A. 18a-19a, 21a-26a).

ULL has found it necessary from time to time to solicit the advice of medical professionals concerning whether certain chiropractic treatments, for which its insureds were seeking reimbursement, were within these express policy coverage limits. It has found the NYSCA peer review committee to be an excellent source for such advice. The chiropractors who volunteer to serve on the committee are well qualified with substantial practice experience and represent a cross-section of different theories of treatment and practices in various localities. Thus, the committee has "provided an essential expertise in the interpretation and application of the policy coverages and limits." (J.A. 20a).

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5 The ULL policies involved in the present action provide major medical or supplemental accident expense coverages in addition to basic health insurance benefits. J.A. 18a-19a, 21a-26a.

ULL's premium rates are based primarily on expenses and loss experience. ULL's minimum anticipated loss ratio is fixed by the Superintendent. (State of New York, *Official Compilation of Codes, Rules and Regulations* tit. 11, § 52.45[c]). Therefore, ULL is required to administer claims as efficaciously as possible so as to minimize loss experience. The soliciting of advice from a peer review committee can be an essential element in this process.

NYSCA's peer review committee upon inquiry by ULL advises as to such matters as the necessity or propriety of the particular chiropractic treatment rendered or the reasonableness of the fees charged. Among the matters considered by the committee are: the treating chiropractor's experience and specialty degrees; the location of his office; the number of visits and amount of time spent with the patient; the patient's age, occupation, general physical condition and history of prior treatment; and x-ray findings. (J.A. 19a; R. 36, Davis Affidavit, Exs. G, H; 650 F.2d at 388, App. A at 4a). However, ULL, its policyholders and the treating chiropractor are not bound by the decision of the peer review committee. As accurately noted in the decision of the District Court below (1979-2 Trade Cas. [CCH] at 78,375, App. B at 24a-25a):

> [A]fter the Committee renders its opinion the insurer remains free to reject it and make its own determination of its liability under its policy. Moreover, absent his consent to a binding determination, the patient remains free to contest the insurer's evaluation of the "reasonableness" of his claim and may bring suit to enforce the terms of his policy. . . . If the chiropractor does not accept . . . an assignment, of course, the patient is obligated to pay the chiropractor's entire fee notwithstanding the refusal of the insurer to pay all or part of the claim.

Without peer review, ULL might have to retain on its staff at substantial expense an experienced chiropractor. However, the opinion of a single staff chiropractor is much less meaningful than the opinion of an independent committee composed of

practicing chiropractors who separately are familiar with various medical conditions, schools of treatment and ranges of fees prevailing in different localities. Indeed, the single staff chiropractor undoubtedly would have to consult other practicing chiropractors as to the propriety of certain treatments or fees charged. Furthermore, if the opinion of the staff chiropractor were disputed by the treating chiropractor, it would be necessary to refer the dispute to a mediator such as the NYSCA peer review committee. (J.A. 20a).

Proceedings Below

The District Court

Pireno commenced this action against ULL and NYSCA[6] in September, 1976 seeking declaratory and injunctive relief and damages for an alleged violation of section 1 of the Sherman Act, 15 U.S.C. § 1, and for defamation. Pireno contends that ULL's utilization of NYSCA's peer review committee has acted to limit chiropractic fees and restrain trade. However, he claims no loss of patients (R. 33, Pireno Deposition at 102; R. 34, Pireno Deposition at 138, 141; R. 44, Pireno Deposition at 48, 56-57) and no loss of income (R. 33, Pireno Deposition at 70, 104, 108; R. 44, Pireno Deposition at 48, 67-69; R. 45, Pireno Answer to ULL Interrogs. 1 and 3).

Among the allegations of Pireno's complaint is that purchasers of chiropractic services from him "have been deprived of the insurance coverage to which they are entitled by [ULL] under the terms of its insurance policies." (J.A. 8a). Pireno's demand for relief includes, *inter alia*, a judgment that ULL "be required to cancel those provisions of its insurance policies and every other rule or statement of policy which has the purpose or effect of suppressing or restricting free and open competition in the sale of chiropractic services." (J.A. 9a).

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6 Pireno also named the International Chiropractors Association as defendant. However, the action against said defendant subsequently was dismissed with prejudice pursuant to a stipulation so ordered by the District Court. 650 F.2d at 389-90 n.4, App. A at 7a n.4.

After extensive discovery proceedings by the parties, ULL and NYSCA each moved for summary judgment. The District Court granted the motions and dismissed Pireno's claims, holding that the peer review activity involved is expressly exempted from federal antitrust laws by the McCarran-Ferguson Act.

The District Court, after analyzing the facts in relation to this Court's decisions in *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969) and *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979),[7] determined that ULL's use of peer review is within the "business of insurance" exemption contained in section 2(b) of the McCarran-Ferguson Act as interpreted by this Court. The District Court differentiated peer review from the provider agreements in *Royal Drug* as follows (1979-2 Trade Cas. [CCH] at 78,377, App. B at 29a-31a):

> In the instant case, by contrast, ULL's insureds are intimately and directly concerned with the peer review arrangement between ULL and the NYSCA's Committee. Unlike the arrangement between Blue Shield and participating pharmacies, the peer review arrangement between ULL and the Committee serves to define the precise extent of ULL's contractual obligations to its insureds under their policies. Peer review may enable ULL to reduce its costs, but it does so through interpretation of the contractual relationship between insurer and insured.

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7 In *National Securities*, this Court set out the definition of the "business of insurance," stating, *inter alia*, that: "The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.'" 393 U.S. at 460. Applying the same criteria in *Royal Drug*, this Court held that "provider agreements" that fixed the price of products furnished by participating pharmacies to subscribers of a health services plan, and which served only to minimize the insurer's costs, were not the "business of insurance" within the meaning of the McCarran-Ferguson Act exemption. See discussion at Point I *infra*.

> Determination of the rights of an insured under his policy is the "core of the business of insurance." Peer review, moreover, involves the spreading of risk, an indispensable element of the "business of insurance." The defendants determine the extent to which an individual insured must bear the full cost of chiropractic services, or instead have that cost borne by the insurer (and, through higher premiums, his fellow insureds). The Committee's role in evaluating claims submitted for review is thus akin to that played by the licensed adjuster, long an important figure in the settlement of claims against insurers. The court thus concludes that ULL and the Committee are engaged in the "business of insurance." (Citations omitted).

The District Court determined that the regulation and supervision of health insurers under the New York Insurance Law and the New York antitrust law provide the state regulation required by section 2(b) of the McCarran-Ferguson Act. (1979-2 Trade Cas. [CCH] at 78,377-78, App. B at 31a-32a). The court held also that there was no "boycott, coercion, or intimidation" so as to come within the exception to the exemption contained in section 3(b) of the Act because Pireno's complaint failed to allege that peer review constitutes such activity and failed even to allege facts which fall within the scope of that exception. (*Id.* at 78,378-79, App. B at 33a-36a).[8]

The Court of Appeals

The Court of Appeals for the Second Circuit reversed the judgment of the District Court and remanded for further proceedings.

The Second Circuit concluded that this Court in *Royal Drug*, notwithstanding its explicit repetition of the definition

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8 Upon the infirmity of Pireno's federal antitrust claim, the District Court dismissed Pireno's state defamation claim for lack of subject matter jurisdiction. 1979-2 Trade Cas. (CCH) at 78,379, App. B at 36a-37a.

of the "business of insurance" laid down in *National Securities,* intended to abandon that definition in favor of a much narrower definition which restricts the "business of insurance" only to an activity which either transfers risk from insured to insurer or spreads the risk among insureds. Applying this analysis, the Court determined that peer review is not part of the "business of insurance" because it is only "an aid in determining the scope of the transfer after it has been made." (650 F.2d at 393, App. A at 15a).

The Second Circuit further concluded that *Royal Drug* excluded from the "business of insurance" activities that are "simply a form of cost reduction." (*Id.*). Since the Court perceived that peer review serves only to reduce costs, it ruled that an insurer's use of peer review is not entitled to the McCarran-Ferguson Act antitrust exemption.

Because its interpretation of the "business of insurance" was dispositive, the Second Circuit found it unnecessary to rule on the lower court's holding that ULL's use of peer review was regulated by New York State and that there was neither an allegation nor showing relative to the boycott exception.[9]

SUMMARY OF ARGUMENT

Peer review can be an essential aid in the proper interpretation and enforcement of specific provisions of health insurance policies. It is the only practical means whereby a health insurer can obtain expert advice from a cross section of the medical community as to such matters as whether certain treatments were medically necessary or whether the fees charged were within the range of reasonable and customary charges prevailing in a particular community. The advice received through the peer review process is used solely to determine the scope of the insurer's underwriting obligations under the policy and there-

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9 Since Pireno did not appeal the dismissal of the defamation claim, the Circuit Court made no ruling concerning it.

fore directly concerns the relationship between the insurer and insured. As such, peer review is an integral part of the "core" of the "business of insurance" under the criteria long established by this Court for construction of the federal antitrust exemption mandated by the McCarran-Ferguson Act.

The decision of the Second Circuit below is based on an unfortunate misreading of *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). It erroneously suggests that this Court therein abandoned the generally understood definition of the "business of insurance" set out in *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), as including activities pertaining to the interpretation and enforcement of the insurance contract, and would result in many common insurance practices that are extensively regulated by the states being excluded from the "business of insurance."

The Second Circuit's decision, if allowed to stand, will result in substantial infringement upon state regulation of the activities of insurance companies by subjecting state authorized and supervised claims settlement practices to the threat of federal antitrust attack. This is a clear violation of the purpose of Congress in enacting the McCarran-Ferguson Act.

Since the peer review process as used in this case is part of the business of insurance regulated by the state and involves no boycott, coercion or intimidation, petitioners are exempted from the present federal antitrust challenge under the express provisions of the McCarran-Ferguson Act.

ARGUMENT

I.

PEER REVIEW DIRECTLY INVOLVES THE RELATIONSHIP BETWEEN INSURER AND INSURED AND IS ESSENTIAL TO A PROPER INTERPRETATION AND ENFORCEMENT OF THE INSURANCE POLICY, ACTIVITIES WHICH THIS COURT HAS HELD TO BE THE "CORE" OF THE "BUSINESS OF INSURANCE"

This Court in *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969) formulated the basic criteria for determining whether conduct constitutes the "business of insurance" within the meaning of section 2(b) of the McCarran-Ferguson Act, as follows (393 U.S. at 460):

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, *interpretation, and enforcement*—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the *relationship between the insurance company and the policyholder.* (Emphasis added).

Applying the same criteria in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), this Court ruled that "provider agreements" that fixed the price of products furnished by participating pharmacies to subscribers of a health services plan were not the "business of insurance" within the meaning of the McCarran-Ferguson Act exemption. The Court in *Royal Drug* found it necessary to distinguish between an insurance contract and a provider agreement. The former is between insurer and insured and includes the essential elements of underwriting and spreading of the policy-

holder's risk. The latter is between the insurer[10] and a seller of goods or services and involves no underwriting or spreading of risk; it serves only to minimize the insurer's costs in fulfilling its specified underwriting obligations. The provider agreement, therefore, was deemed to be no different than countless other business contracts of insurance companies designed to keep their costs low.

The decision in *Royal Drug* reaffirms that "the business of insurance relates to the contract between the insurer and the insured" (440 U.S. at 215) and reiterates with approval the criteria in *National Securities* quoted above. Since the provider agreements did not involve the interpretation and enforcement of the insurance policy or the relationship between insurer and insured, but merely provided for the purchase of goods, they were held not to meet the requisite "business of insurance" criteria.

A. Use of Peer Review by a Health Insurer Falls Squarely Within the "Business of Insurance" Criteria Laid Down by This Court.

The sole purpose of peer review as used by ULL is to assist in determining whether or to what extent reimbursement is due

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10 The decision of this Court in *Royal Drug* did not concede that health service organizations such as Blue Cross are "insurers." *See* 440 U.S. at 225-30. The decision noted that it is "highly significant in ascertaining congressional intent" that such organizations were not commonly understood at the time of enactment of the McCarran-Ferguson Act to be engaged in providing insurance. *Id.* at 227. However, it cannot be disputed that ULL's policies, being the traditional indemnity policies and paying money directly to the insured for his or her loss, would have been considered by Congress at the time of the passage of the McCarran-Ferguson Act to be the "business of insurance." *See generally* Hanson, *The Private Insurance Industry and State Insurance Regulatory Activities as Alternatives to Federally Enacted Comprehensive National Health Insurance Legislation*, 6 U. Tol. L. Rev. 677, 690-91 (1975). Nor can it be seriously argued that ULL's policies do not constitute the "business of insurance" in the current "ordinary understanding" of that phrase, *Royal Drug*, 440 U.S. at 211. *See id.* at 230 n.37; *id.* at 239 (Brennan, J., dissenting). *See generally* Hanson, *supra*, at 689 n.39.

an insured under the terms of the policy arising from particular chiropractic treatment. Questions at times occur as to whether the treatment was medically necessary or within the doctor's license to practice or whether the fees charged for the particular treatment were reasonable or in excess of the range of usual and customary charges prevailing in a particular community.[11] Proper resolution of these questions, which is made possible by the advice of medical professionals through the peer review process, is essential to equitable enforcement of the benefits and limitations set forth in the policy terms.

Peer review helps to ascertain whether a reimbursement claim for chiropractic treatment is within the scope of the risks covered by the policy terms. The determination of this question by the insurer directly bears on the amount of dollars that will be paid on the claim—a matter of primary concern to the insured.

Significantly, all federal courts that have considered the question, save the Second Circuit, have ruled that a health insurer's use of peer review falls within the "business of insurance" exemption of the McCarran-Ferguson Act as interpreted by this Court. In *Bartholomew v. Virginia Chiropractors Association*, 612 F.2d 812 (1979), *cert. denied*, 446 U.S. 938 (1980),[12] the Fourth Circuit held that health insurers who consulted peer review committees of professional chiropractic associations, as well as the associations and individual chiropractors who served on the committees, could not be sued under the federal antitrust laws. The decision recognized the

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11 Where claims personnel are uncertain as to the propriety of the claim for reimbursement, the insurer is required by New York State law to make reasonable and prompt investigation. See Point II *infra*. Peer review provides an expeditious and cost-efficient means of fulfilling this requirement.

12 The opinion of the District Court below, now overturned by the Second Circuit, was cited in *Bartholomew* as "an especially clarifying discourse" on the issues involved in this case. 612 F.2d at 817.

distinction between peer review and the provider agreements in *Royal Drug*, as follows (612 F.2d at 817):

> In that case there were two segregated and disparate operations: one, the offering of insurance, and the other, the procurement of drugs, admittedly an act only thinly tangential to insurance. Obtaining drugs under the Pharmacy Agreement was a business of the insurance companies, not the business of insurance. *Royal Drug* at 218, 99 S.Ct. 1067, n.18. In the present instance, there is an integration of component acts resulting in a single composite business—insurance.

Bartholomew has been followed by the District Court of Maryland in *Ratino v. Medical Service of the District of Columbia*, 1981-1 Trade Cas. (CCH) ¶ 64,144 at 76,860 (D. Md. 1981) ("The peer review process was, therefore, part of the process of interpretation of the insurer's obligations to the insured which is at the heart of the business of insurance.")

In *Gerimonte v. Washington Chiropractors Association*, No. C81-40R (Oct. 16, 1981) (Slip op., ULL Reply Br. App.),[13] the District Court for the Western District of Washington, in a factually identical case, was confronted with a choice between the Fourth Circuit's holding in *Bartholomew* or the Second Circuit's opinion below. Finding the latter "not . . . persuasive" (Slip op. at 4-5, ULL Reply Br. App. at 6a) and the rationale of *Bartholomew* to be sound, the District Court stated as follows (Slip op. at 5, ULL Reply Br. App. at 6a):

> The peer review system serves to determine the extent of the insurers' contractual obligations to their policyholders. The insurance contracts limit reimbursement to usual, customary, and reasonable charges for necessary

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13 Parenthetical references to "ULL Reply Br. App." refer to the Appendix to ULL's Reply Brief to the Brief of Respondent A. Alexander Pireno in Opposition to the Petition for a Writ of Certiorari.

> health care services rendered. The determination of usual and customary charges is done through the mechanism of the peer review committee. The interpretation of the terms of the policy, which will in turn determine the rights of the policyholder, is of direct and immediate concern to the insured. When Congress enacted the McCarran-Ferguson Act it was concerned with precisely this relationship between insurer and insured—the "core of the 'business of insurance.' " The focus of Congress was "on the relationship between the insurance company and the policyholder." *Royal Drug*, 440 U.S. at 215, *citing*, *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1968).

Thus, it seems clear that a health insurer's use of peer review falls within the scope of the "business of insurance" under the criteria laid down by this Court.

B. The Second Circuit in Narrowly Defining the "Business of Insurance" so as To Exclude a Health Insurer's Use of Peer Review Has Erroneously Interpreted This Court's Decision in *Royal Drug*.

The Second Circuit has read *Royal Drug* as abandoning the long accepted and generally understood definition of the "business of insurance" set out in *National Securities*. The lower court suggests that many common insurance practices that are extensively regulated by the states—such as adjustment and settlement of losses—would no longer be deemed part of the "business of insurance." Indeed, the decision inexorably leads to the conclusion that all efforts of insurers relating to enforcement and interpretation of insurance policies—where the effect tends to contain costs—are subject to the substantial risks, burdens and cost of antitrust litigation.

The Second Circuit's decision states, in pertinent part, that: "*Royal Drug* sets forth a substantially narrower scope for the 'business of insurance' exemption than its approving citation of *National Securities* might suggest." (650 F.2d at 394, App. A at 17a).

Nothing in *Royal Drug* supports the rejection of the *National Securities* criteria for delineating the "business of insurance." This Court simply concluded in *Royal Drug* that the provider agreements did not meet those criteria because they were not agreements between insurer and insured and because the only argument advanced by Blue Shield—that the pharmacy agreements related to the company's "status as a reliable insurer" since they reduced costs—went too far, in that such a construction would mean that "almost every business decision of an insurance company could be included in the 'business of insurance.' " (440 U.S. at 217). This Court also was influenced by the fact that the provider agreements had a "wholly separate nature" from the insurer's obligations under the policy and involved matters with which insureds are "basically unconcerned." (440 U.S. at 216 n.14, 214 & n.11).

The situation is entirely different with respect to peer review. Peer review directly involves the "interpretation" and "enforcement" of the insurance contract and has no other function separate from the implementation of the insurance contract. Peer review certainly cannot be said to involve matters with which policyholders are "basically unconcerned." It goes to the very heart of the policyholder's concern—the amount of reimbursement forthcoming under the terms of the insurance contract. Nor can it be said that peer review is merely a cost-reduction device indistinguishable from countless other ways in which insurance companies can save money. To the extent peer review helps reduce costs, it does so solely by aiding in the implementation of the insurance policy limits. Hence, unlike the provider agreements in *Royal Drug*, it cannot be said that including peer review within the "business of insurance" would expand the exemption to every business decision of an insurance company. Peer review relates entirely to the interpretation and enforcement of the insurance contract and is, therefore, within the "core" of the "business of insurance" as defined in both *National Securities* and *Royal Drug*.

The Second Circuit's decision also misreads *Royal Drug* in giving the test of underwriting and risk-spreading used by this

Court, as one definition of the "business of insurance," an unduly narrow construction in applying it to peer review. The Second Circuit states (650 F.2d at 393, App. A at 14a-15a):

> Nor does [peer review] transfer risk. The risk that an insured will require chiropractic treatment has been transferred from the insured to the insurer by the very purchase of insurance. Peer review takes place only after the risk has been transferred by means of the policy, and then it functions only to determine whether the risk of the entire loss (the insured's cost of treatment) has been transferred to the insurer—that is, whether the insured's loss falls within the policy limits. Peer review is thus not a means of transferring risk from insured to insurer. At most, it is an aid in determining the scope of the transfer after it has been made.

Later, the Second Circuit states that peer review does not transfer risk but "on the contrary, peer review merely measures the extent to which a policyholder has failed to effect such a transfer." (*Id.*, App. A at 15a).

This Court's opinion in *Royal Drug* provides no basis for such semantic and unrealistic distinctions. It is inconceivable that Congress would have included risk transfer within the "business of insurance" but excluded a device that helps "determine whether the risk . . . has been transferred" and acts as "an aid in determining the scope of the transfer." This is particularly true inasmuch as the underwriting and risk transfer decisions reflected in policy provisions limiting reimbursement to "reasonable" and "customary" charges—flexible concepts which can vary over time and from community to community—do not become concrete until applied to specific claims through claims settlement procedures such as peer review. And, of course, peer review not only helps determine the extent to which risk is not transferred, but the extent to which risk *is* transferred. Even viewed in the light of the Second Circuit's characterization, peer review is a device which helps implement and make meaningful the underwriting, risk-

spreading and risk transfer decisions reflected in the insurance policy. As such, peer review is an integral part of the underwriting process not logically distinguishable for purposes of applying the exemption for the "business of insurance."

Another fundamental error in the Second Circuit's reasoning is its conclusion that peer review is outside the "business of insurance" because it is "simply a form of cost reduction." (650 F.2d at 393, App. A at 15a). This aspect of the Second Circuit's decision is also based on a misreading of *Royal Drug*. *Royal Drug* involved agreements between Blue Shield and pharmacists fixing the price of drugs sold by the pharmacists to Blue Shield subscribers. This Court concluded that these contracts were outside the "business of insurance" because they were "merely arrangements for the purchase of goods and services." (440 U.S. at 214). The defendants argued, however, that the pharmacy agreements should nevertheless be considered the "business of insurance" because those agreements permitted the insurance company to reduce its costs in fulfilling its obligations to its insured, which in turn, resulted in lower premium charges to insureds. This Court rejected that argument, concluding that if it were accepted, then no rational line could be drawn between the pharmacy agreements and "countless other business arrangements that may be made by insurance companies to keep their costs low and thereby also keeping low the level of premiums charged to their policyholders." (440 U.S. at 215).

Thus, *Royal Drug* simply rejected the argument that a practice comes within the "business of insurance" merely because it serves to reduce costs. But it does not follow that if a practice tends to reduce costs, it is, for that reason, outside the "business of insurance." If this were so, then typical provisions in the insurance contract that function to reduce claims costs would automatically fall outside the "business of insurance." Indeed, most provisions that can be characterized as underwriting, risk-spreading or risk transfer provisions are designed to reduce costs. This is the obvious function of such typical insurance contract provisions as coverage deductibles, under-

writing exclusions, co-insurance factors and risk limitations."[14] Certainly, this Court never intended to suggest that such insurance policy provisions fall outside the "business of insurance" because their function is "merely to reduce costs."

Furthermore, it is untrue, as the Second Circuit concluded, that peer review always results in a reduction of insurer's costs. The function of peer review is to aid in assuring that the insurance policy benefits and limitations are enforced fairly and in accordance with the customary and reasonable standards set forth in the policy terms. Thus, the peer review process may provide information to the insurer which will result in full reimbursement of a policyholder's claim that otherwise would not have been paid.[15] In such circumstances, peer review obviously does not serve to reduce the insurer's costs.

In some cases, peer review may help reduce costs in the manner described by the Second Circuit: by aiding in proper policy interpretation, it may avoid indemnity for charges and

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14 *See, e.g.*, A. Erickson, *The Group Health Insurance Claim* 158 (1967) ("Underwriting entails the language to be used including the use of built-in controls such as inside and outside benefit maximums, pre-existing, deductible, co-insurance, non-duplication, and other provisions."); Johnson, *Deductibles, Experience Rating and Loss Cost Minimization*, 29 C.P.C.U. Annals 36, 36 (1976) ("The use of deductibles as a risk management technique has often been recognized and discussed."); M. Smith, *A Reexamination of Coinsurance Clauses*, 47 J. Risk & Ins. 506 (1980).

15 A commentator has noted this result in a similar context:

> Utilization review involves a committee of physicians who review the type and quality of medical care provided to hospitalized patients. . . . Those cases that deviate widely from normal or usual patterns can then be reviewed and investigated. . . . Unresolved problem cases can be referred to the appropriate hospital or medical society committee for their assistance. The patient is thereby protected against economic exploitation, while the practicing physician is protected against arbitrary and capricious judgment.

G. Rejda, *Social Insurance and Economic Security* 203 (1976).

treatments that fall outside the policy limits. It also permits more precise enforcement of the policy limitations, thus helping to minimize increases in the cost of medical services indemnified by the insurance contract. (650 F.2d at 393, App. A at 15a-16a). But reducing costs in this way is the very essence of the "business of insurance" because it helps carry out the underwriting decisions written into the insurance contract by more precise "interpretation" and "enforcement" of the policy. Unlike the pharmacy agreements in *Royal Drug*, it cannot be said that the cost-reduction function of peer review is indistinguishable "from countless other business arrangements" by which the insurance company purchases goods and services.

For these reasons, ULL submits that the Second Circuit's decision reflects an incorrect reading of *Royal Drug* and that the correct reading is reflected in the District Court's decision, followed by the Fourth Circuit and two federal district courts, that peer review is the "business of insurance" within the meaning of the McCarran-Ferguson antitrust exemption.

C. The Decision Below Erred in Holding That Peer Review as Part of the Claims Adjusting Function Does Not Constitute the "Business of Insurance."

The Second Circuit agreed with the District Court[16] that peer review involves an insurance claims adjusting function. (650 F.2d at 394, App. A at 18a). Nevertheless, the Court concluded that that fact did not convert peer review into the "business of insurance" (650 F.2d at 394-95, App. A at 18a):

> First, it is by no means clear that claim-settlement itself constitutes "the business of insurance" within the meaning of the antitrust exemption as interpreted in *Royal Drug*. Second, it remains true that the peer review committee is not a member of the insurance industry, and that

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16 The District Court observed that the peer review committee's role is "akin to that played by the licensed adjuster, long an important figure in the settlement of claims against insurers." 1979-2 Trade Cas. (CCH) at 78,377, App. B at 30a.

> the antitrust exemption seeks primarily to shield agreements among insurers, not those between insurers and persons outside the industry. (Citations omitted).

Petitioner submits that both these statements are unsound.

The suggestion that claims adjustment no longer constitutes the "business of insurance" apparently stems from the Second Circuit's conclusion that the activity occurs after transfer of the risk and that any such activity, even though it serves to define the scope of the insured risk, cannot qualify for the exemption. However, claim adjustment cannot logically be separated from risk transfer or spreading so as to be said to occur at a later point in time.[17] Furthermore, this Court in *Royal Drug* indicated that the underwriting or spreading of risk is only *one* test of whether conduct constitutes the "business of insurance." The Court reiterated that: *"Another* commonly understood aspect of the business of insurance relates to the contract between the insurer and the insured." (440 U.S. at 215, emphasis added). Claims adjustment, including an insurer's collection of information through the peer review process, directly involves both risk transfer and spreading and the interpretation and enforcement of the terms of the insurance contract, matters directly involving the relation between insurer and insured.

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17 As this Court recognized in *Royal Drug*, 440 U.S. at 211-13, "risk spreading" in insurance actually means the spreading of losses:

> "It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such *losses are spread* over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it." 1 G. Couch, Cyclopedia of Insurance Law § 1:3 (2d ed. 1959). . . .
>
> . . . Cf. *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, 412 ("The effect of insurance—indeed it has been said to be its fundamental object—is to *distribute the loss* over as wide an area as possible"). (Emphasis added).

Since claims adjustment determines the *amount of loss to be spread*, it makes no sense to say that the activity is divorced from underwriting and spreading of risk.

As one commentator has noted:

> [T]he adjuster's decisions "involve" the underwriting of risk in a fundamental way: they are a culmination of routine practices expressly designed to determine whether the loss falls within the class of risks that the insurer underwrote on the issuance of the policy. Moreover, claims adjusting is the business of insurance because the adjuster's decisions interpret the contractual obligations of insurer and insured by determining the extent of the insurer's liability. Such decisions intimately affect the contractual relationship between the two parties, thus satisfying the second aspect of the business of insurance under *Royal Drug*.

(Comment, *The Scope of the "Business of Insurance" Provision of the McCarran-Ferguson Act: Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 65 Minn. L. Rev. 1187, 1202 [1981]).

Claims adjustment procedures recently have been noted by a federal court to be "an important determinant of commonly made rates and the spreading of risk." (*Proctor v. State Farm Mutual Automobile Insurance Co.*, 1980-81 Trade Cas. [CCH] ¶ 63,591 at 77,139 [D.D.C. 1980], *appeal docketed*, [D.C. Cir. Nov. 14, 1980]).[18]

Certainly, the "ordinary understanding"[19] of the public, insurance authorities and state regulators long has held that

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18 The District Court in *Proctor* observed that the Department of Justice in its *amicus* brief in *Royal Drug* had agreed that horizontal agreements *"concerning the extent to which particular claims would be paid"* were exempt under McCarran-Ferguson. 1980-81 Trade Cas. (CCH) at 77,140.

19 This Court, in *Royal Drug*, 440 U.S. at 211, noted that a proper interpretation of the "business of insurance," which is undefined by statute, must look in major part to the "ordinary understanding" of that phrase, citing *Ernst & Ernst v. Hochfelder*, 425 U.S. 185, 199 n.19 (1976), which reads as follows:

(footnote continued on following page)

claim adjustment is a key component of the "business of insurance." Insurance normally is purchased with the full expectation that the insurer will meet its policy obligations at the time of a claim through proper claim administration.[20] As one insurance commentator has observed:

> Up until the time there is a claim and a payment is made, the only tangible evidence of insurance is a piece of paper. In other words, the real product of insurance is the claim proceeds. Selection of the prospect, qualifying him for coverage that suits his needs, delivery of a policy, collecting premiums for perhaps years, making changes in coverage to meet changing situations, all these are but preambles to the one purpose for which the insurance was secured, namely to collect dollars if and when an unforeseen event takes place.

(J. Wickman, *Evaluating the Health Insurance Risk* 57 [1965]).

That the claims settlement process, including peer review, must be part of the "business of insurance" is further demonstrated by the legislative history of the McCarran-Ferguson Act. The bill submitted to Congress by the National Association of Insurance Commissioners ("NAIC"), which formed the

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"To let general words draw nourishment from their purpose is one thing. To draw on some unexpressed spirit outside the bounds of the normal meaning of words is quite another. . . . After all, legislation when not expressed in technical terms is addressed to the common run of men and is therefore to be understood according to the sense of the thing, as the ordinary man has a right to rely on ordinary words addressed to him." *Addison v. Holly Hill Fruit Products, Inc.*, 322 U.S. at 617-618. See Frankfurter, Some Reflections on the Reading of Statutes, 47 Col. L. Rev. 527, 536-537 (1947).

20 C. Cissley, *Claim Administration: Principles and Practices* iii (1980). *See also* F. Angell, *Insurance Principles and Practices* 780 (1959). Indeed, the insurance contract traditionally has been viewed as not fully executed until payment by the insurer of a sum after a loss that is covered by the contract. 1 *Couch on Insurance* 2d § 1:5 (1959).

basis of the McCarran-Ferguson Act,[21] specifically listed claims adjustment as an activity that required exemption.[22] This is unlike provider agreements which this Court in *Royal Drug* noted were not listed in the NAIC bill.

There is clear indication that Congress understood the meaning of the "business of insurance" to include claims activities. The McCarran-Ferguson Act was enacted in 1945 in response to this Court's decision in *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944).[23] The beneficial cooperative activities challenged in *South-Eastern Underwriters*, which Congress intended to preserve under state regulation, included not only rate-making,[24] but also claim activities:

> A great number of fire-insurance companies have cooperated in mutual agreement—and of necessity—through the

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21 *Royal Drug*, 440 U.S. at 221. The Court found it significant that provider agreements were not among and did not resemble in any way the specific list of exempted activities contained in the NAIC bill. *Id.* at 222, 223-24 n.30.

22 Section 4(b)(3) of the NAIC bill provided that, "the said Sherman Act shall not apply . . . (3) to any cooperative or joint service, *adjustment, investigation, or inspection agreement relating to insurance, or to acts under such agreements.*" 90 Cong. Rec. A4406 (1944) (emphasis added).

23 *Royal Drug*, 440 U.S. at 217; *National Securities*, 393 U.S. at 458.

24 While the primary focus of Congress concerning the antitrust exemption may have been cooperative rate-making activity, *Royal Drug*, 440 U.S. at 221-24, the antitrust exemption provided by the McCarran-Ferguson Act clearly was not intended to be limited to such activities. Representative Miller explained: "I emphasize the subject of rates and rating bureaus because, although other phases of the insurance business are also involved in the question before us, they represent the core of the problem." 90 Cong. Rec. 6527 (1944). Consequently, this Court has held that: "The selling and advertising of policies, *FTC v. National Casualty Co.*, 357 U.S. 560 (1958), and the licensing of companies and their agents, cf. *Robertson v. California*, 328 U.S. 440 (1946), are also within the scope of the statute." *National Securities*, 393 U.S. at 460.

> Southeastern Underwriters Association and rating bureaus, adjusting policy rates to risks, classifying insurable property, either in co-insurance or in re-insurance, *making appraisals of losses,* and working out systems of inspection to improve protection against fires. All of this has been done with splendid success. It would be a pity indeed, after all these years, to have the Government intervene. The business of insurance involves long contracts. The fidelity of performance of those contracts will not brook intervention.

(90 Cong. Rec. 6530 [1944] [remarks of Rep. Satterfield] [emphasis added]; *see also id.* at 6543 [remarks of Rep. Jennings] [emphasizing that the purpose of insurance is to pay claims]; *id.* at 6550-51 [remarks of Rep. Ploeser] [noting need for the constant improvement of claims activities]).

We submit that it is also erroneous to conclude, as the Second Circuit has done, that ULL's use of the peer review process is outside the scope of the "business of insurance" simply because NYSCA is not an insurance company.[25]

There is nothing in the McCarran-Ferguson Act that limits the "business of insurance" to the business of insurance companies. As this Court has stated, "[the Act's] language refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the *business* of insurance.' " *National Securities,* 393 U.S. at 459.

This case deals with the wording of the insurance policy and the collection of information necessary for the insurer to determine whether and to what extent an insured is entitled to

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25 The peer review committee can be said to operate within the insurance industry as agents of the insurer to the limited extent of supplying information necessary for proper claims adjustment. *See* Brief *Amici Curiae* of the American Insurance Association, the Alliance of American Insurers, and the National Association of Independent Insurers.

be reimbursed upon presentment of a claim—matters heretofore considered to be the "core" of the "business of insurance." Such activities are regulated extensively by New York State law (*infra*, Point II). Application of the provisions of the Sherman Act would supersede this state regulation in direct contravention of the McCarran-Ferguson Act.

The Second Circuit's desire to limit the antitrust exemption strictly to members of the insurance industry apparently arises from its concern that persons outside the industry are not "within the jurisdiction of state insurance authorities." (650 F.2d at 390 n.5, App. A at 8a n.5). This overlooks the fact that the Superintendent of Insurance effectively can regulate the peer review process through his authority over the claims adjustment procedures of ULL.[26] If the Superintendent determines that ULL's use of information gathered through the peer review process does not constitute a fair settlement practice, he can either order ULL to cease and desist from using it altogether or condition ULL's continued use of peer review upon appropriate modifications in the procedure. Absent ULL's participation, the peer review activities obviously no longer could be considered part of the "business of insurance" and would be subject to federal antitrust challenge.[27]

Similarly, any activity of health care professionals that goes beyond this limited function of furnishing medical advice

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26 Pireno conceded in the court below that if the insured is unsatisfied with the disposition of his or her claim as a result of peer review, recourse is available through "suit against the insurer, or *complaint to the Insurance Department.*" Brief for Plaintiff-Appellant in the C.A.2d at 2 (emphasis added).

27 If necessary to consider the state regulation applicable to each party, as well as the activity involved, the Superintendent, through his authority to control ULL's use of the peer review process, may be said to exercise at least an *indirect* control over NYSCA's methods of providing information. *Cf. National Securities*, 393 U.S. at 460: "Statutes aimed at protecting or regulating this [insurer-insured] relationship, *directly or indirectly*, are laws regulating the 'business of insurance.' " (Emphasis added).

necessary to resolve a coverage question under the policy terms would not be shielded by the antitrust exemption. No such allegation is made in the present case; Pireno's entire complaint is based on ULL's use of the advice obtained from the peer review committee in adjusting claims.[28]

The decision of the Second Circuit appears to adopt a mechanistic rule that excludes from the "business of insurance" any activity involving persons outside the insurance industry. Such a rule produces illogical results. For example, independent licensed adjusters, having no medical training whatsoever, could advise health insurers without fear of antitrust challenge as to whether particular medical treatment was necessary or appropriate; independent medical professionals could not.[29] Similarly, a staff physician on the payroll of the insurance company[30] presumably would be deemed to be within the insurance industry and could advise the insurer of the appropriateness or reasonableness of another physician's treatment. However, his practicing colleagues, who are likely to be more knowledgeable of current methods of treatment, could not render such advice.

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28 *See Amicus Curiae* Brief of the National Association of Insurance Commissioners in Support of Petitioners ("Brief of NAIC") urging that this Court adopt an "adjuster analysis" in the present case as one step in structuring "a 'principled basis upon which a line can rationally be drawn' between true insurance activities and mere business activities of insurance companies."

29 Congress has recognized that "only physicians are, in general, qualified to judge whether services ordered by other physicians are necessary." S. Rep. No. 1230, 92d Cong., 2d Sess. 256 (1972). *See generally* Brief of Amici Curiae Health Insurance Association of America and the American Council of Life Insurance.

30 An accident and health insurer having a relatively small number of chiropractic claims might find it economically prohibitive to employ a chiropractor to review the propriety of such claims. Thus, such an insurer might seek to avoid underwriting altogether services that are likely to involve chiropractic treatment. The reduction in availability of this coverage undoubtedly would be a matter of concern to state insurance departments.

D. The Threat of Federal Antitrust Suits Will Have a Chilling Effect on Peer Review for Which There Is No Practical Alternative in Insurance Policy Interpretation and Enforcement.

It is axiomatic that medical professionals and their associations will be unwilling to volunteer their services for peer review if as a result they may be subjected to the tremendous burdens and costs of federal antitrust litigation. Nor will health insurers be anxious to risk such an exposure. The unfortunate consequence is likely to be the virtual termination of peer review as a means of interpreting insurance policy benefits. The possible alternatives for achieving this essential function either are impractical or themselves subject to federal antitrust challenge under the rationale of the Second Circuit's decision.

Insurer claim personnel often can determine the propriety of reimbursement claims based on experience with similar medical treatments. Nevertheless, the immense variety of human physical ailments frequently compels varying and nonstandard types of treatment, at times by highly specialized practitioners.[31] In addition, rapidly changing technology can result in drastic innovations in types, methods and costs of treatment. Moreover, fees may vary substantially based on the locale of the doctor's practice. It would be unreasonable in the extreme under these circumstances to expect insurance company claim personnel to be able to pass on all reimbursement requests without benefit of expert advice.

Equally unreasonable would be to expect a single chiropractor, if retained by the insurer, to be knowledgeable about all types of patient ailments, schools and methods of treatment, newly adopted practices and procedures and geographic variations. Such a chiropractor, therefore, undoubtedly would find

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31 The lack of standardization is particularly prevalent in chiropractic where there are different "schools" or methods in approaching particular medical conditions. *See, e.g.*, B. Palmer, *The Subluxation Specific—The Adjustment Specific* 18-27 (1934).

it necessary to confer with a number of his colleagues, thereby informally instituting a peer review process without the reliability and safeguards of the peer review process presently available from medical professional associations. Furthermore, this informal type of peer review presumably would encounter the same antitrust challenge which the Second Circuit has authorized in its decision below.

It might be argued that ULL could adopt a schedule of fixed benefits, by specific dollar amounts, for all major medical treatments, thereby supposedly avoiding problems with interpretation of "reasonable" or "regular and customary" charges. Assuming that such a schedule could be devised for the multifarious forms of chiropractic treatment, there still would be questions as to whether certain treatments were "necessary" or arose from "non-occupational accidental bodily injuries" or were rendered "within the scope of the [doctor's] license" to practice. (J.A. 18a-19a, 21a-26a).[32] Such a fixed schedule would require frequent revisions of the policy which in each instance would have to be approved by the Insurance Department. Furthermore, it is difficult to conceive how either the insured or his doctor would be in a better position with a policy-fixed ceiling on benefits rather than with the full benefits for customary and reasonable charges pres-

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32 Even where fixed schedules have been adopted, it has been necessary to provide for corresponding peer review. For example, the Superintendent, after adopting detailed fixed fee schedules relating to reimbursement of medical costs of "no-fault" claimants, found it necessary to promulgate a regulation providing for professional peer review of "whether fees are in accordance with or not specifically covered by the fee schedules promulgated in Part 68 of this Title (Regulation 83), whether treatment, services or hospitalization was excessive or unnecessary, disputes involving charges in excess of the fee schedule, and whether treatment was related to the injury sustained in the motor vehicle accident." State of New York, *Official Compilation of Codes, Rules and Regulations* tit. 11, § 65.16(c)(3)(ii). *See also id.* tit. 12, pts. 328, 342, 347 (similar regulations promulgated to resolve disputes in relation to fee schedules under workers' compensation regulations).

ently provided by the policy provisions approved by the Insurance Department.

Peer review enables the insurance company to underwrite full benefits for the insured's medical costs based on a flexible standard that allows for changes resulting from, among other things, inflation or deflation of costs, new developments in practices and procedures and geographic variations. Peer review advice also helps to resolve differences between insurer and insured that otherwise might lead to litigation or arbitration which would be both unduly expensive in relation to the amounts involved and harmful to the continued underwriting relationship between insurer and insured.

Since there thus is no realistic alternative, peer review is an essential element in health insurers' underwriting practices and in the interpretation and enforcement of insurance policies. It clearly therefore is the "core" of the "business of insurance" and should not be subject to the chilling effect of federal antitrust challenge.

II.

NEW YORK STATE EXTENSIVELY REGULATES ULL'S USE OF PEER REVIEW

The District Court below properly held, in pertinent part, as follows (1979-2 Trade Cas. [CCH] at 78,377, App. B at 32):

> New York has enacted a pervasive scheme of regulation and supervision of insurance. Article IX-D of the Insurance Law prohibits any person from engaging in any "unfair method of competition or unfair and deceptive act or practice in the business of insurance in accordance with the intent of Congress as expressed in [the McCarran-Ferguson Act]." *Id.* § 270. Among the prohibited practices is the unfair settlement of claims. *Id.* § 40-d, 273. The Superintendent of Insurance is empowered to issue cease and desist orders against such practices, *id.* § 276, and may investigate, hold hearings and issue reports concerning unfair practices not specified elsewhere in Article IX-D. *Id.* § 278. The practices complained of by plaintiff are clearly regulated by New York's insurance law.

Article IX-D of the New York Insurance Law (McKinney 1966 & Supp. 1981), upon which the District Court relied,[33]

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33 Article IX-D is based on the original NAIC Model Unfair Trade Practices Act. *See* II NAIC, *Official N.A.I.C. Model Insurance Laws, Regulations and Guidelines* 900-12 (1977); Hanson, *supra*, note 10, at 697-99. The prohibitions against unfair and deceptive insurance practices contained in said Model Act were held by this Court in *FTC v. National Casualty Co.*, 357 U.S. 560 (1958) (per curiam) to constitute the requisite state regulation under McCarran-Ferguson Act section 2(b) so as to oust the Federal Trade Commission from jurisdiction over insurance advertising. New York later added section 40-d of the Insurance Law (McKinney Supp. 1981), 1970 N.Y. Laws ch. 296, § 1, which specifically deals with unfair claim practices. Section 40-d is based on the revised Model Act. *See* Brief of NAIC; Hanson, *supra* note 10, at 697-99. A violation of section 40-d constitutes an unfair trade practice under article IX-D. N.Y. Ins. Law § 273 (McKinney Supp. 1981).

defines an unfair claims practice to include an insurer's failure "to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies." (N.Y. Ins. Law § 40-d[1][c] [McKinney Supp. 1981]). A violation of the statute subjects the insurer to a possible fine up to $500 for each instance of noncompliance. (N.Y. Ins. Law §§ 5, 40-d[3] [McKinney Supp. 1981]). ULL's use of peer review is an attempt to comply with the statute so as to avoid the possibility of the sanction.

ULL actually is subject to even greater state insurance regulation than that noted by the District Court. The Superintendent has adopted a detailed regulation governing unfair claim settlement practices. (State of New York, *Official Compilation of Codes, Rules and Regulations* tit.11, pt. 216). This regulation, *inter alia,* requires insurers to maintain extensive claims files which are subject to the Superintendent's examination. (*Id.* § 216.9). The Superintendent also has established a separate Complaint Bureau within the Insurance Department to process complaints by persons entitled to recover under insurance policies.[34] This enables treating chiropractors, such as Pireno, to seek redress through the Insurance Department by taking an assignment of the insured's claim against the insurer.

ULL operates in New York under the licensing authority of the Superintendent. (N.Y. Ins. Law § 40 [McKinney 1966 & Supp. 1981]). All policy forms issued by ULL must be filed with and approved by the Superintendent and the insurance must be provided at a reasonable cost. (N.Y. Ins. Law § 154[1] [McKinney Supp. 1981]). Section 221(6) of the Insurance Law (McKinney 1966) prohibits issuance of any policy that does "not appear to be self-supporting on reasonable assumptions as to . . . appropriate claim rate . . . and expense."

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34 "Processing complaints [by the state insurance department] not only serves to assist individuals with their particular problems but also provides a means to monitor an insurer's conduct in a more efficient fashion." Hanson, *supra* note 10, at 701-02.

Section 162(2) of the Insurance Law (McKinney 1966) mandates that ULL's premium rates be filed with the Superintendent. Pursuant to provisions of section 221(7) of the Insurance Law (McKinney 1966), the Superintendent requires that each rate filing include "an outline of the essential benefits, coverages, limitations and exclusions to which the rate applies" and "justification" of the rates. (State of New York, *Official Compilation of Codes, Rules and Regulations* tit. 11, §§ 52.40 [e] [2] [iii], [ix]). In addition, ULL's minimum anticipated loss ratio is fixed by the Superintendent. (*Id.* § 52.45[c]).

Similar comprehensive regulatory schemes have been held to satifsy the state regulatory requirement of the McCarran-Ferguson Act. (*See Owens v. Aetna Life & Casualty Co.*, 654 F.2d 218, 226 [3d Cir. 1981], *cert. denied*, __ U.S.__ , 50 U.S.L.W. 3441 [1981]; *Ohio AFL-CIO v. Insurance Rating Board*, 451 F.2d 1178, 1182 [6th Cir. 1971], *cert. denied*, 409 U.S. 917 [1972]; *McIlhenny v. American Title Insurance Co.*, 418 F. Supp. 364, 370 n.5 [E.D.Pa. 1976]; *Schwartz v. Commonwealth Land Title Insurance Co.*, 374 F. Supp. 564, 570-71, 575-77 [E.D. Pa. 1974], *supp. opinion*, 384 F. Supp. 302 [E.D. Pa. 1974]; *Steingart v. Equitable Life Assurance Society*, 366 F. Supp. 790, 794-95 [S.D.N.Y. 1973]).

In addition to state insurance regulation, state antitrust statutes, such as New York's Donnelly Act (N.Y. Gen. Bus. Law § 340 [McKinney 1968 & Supp. 1981]), have been held separately to provide the requisite state regulation. (*See Lawyer's Realty Corp. v. Peninsular Title Insurance Co.*, 428 F. Supp. 1288, 1292 [E.D. La. 1977], *aff'd per curiam*, 550 F.2d 1035 [5th Cir. 1977]; *Steingart v. Equitable Life Assurance Society*, 366 F. Supp. 790, 793-94 [S.D.N.Y. 1973]; *Transnational Insurance Co. v. Rosenlund*, 261 F. Supp. 12, 25-26 [D. Ore. 1966]; *California League of Independent Insurance Producers v. Aetna Casualty & Surety Co.*, 175 F. Supp. 857, 860 [N.D. Cal. 1959]).

The District Court below correctly concluded, in pertinent part, as follows (1979-2 Trade Cas. [CCH] at 78,377-78, App. B at 32a):

> New York's own antitrust law proscribes the conduct alleged in the complaint. The Donnelly Act states that every contract, agreement or conspiracy whereby a monopoly is or may be established is illegal. New York General Bus. Law § 340 (McKinney 1968). The Act was amended in 1948 and specifically made applicable to "licensed insurers . . . and other persons and organizations subject to the provisions of the insurance law." *Id.* § 340(2). On this basis too, the McCarran-Ferguson exemption operates as a bar to plaintiff's federal antitrust claim.

Therefore, New York manifestly satisfies the "state regulation" requirement of the McCarran-Ferguson antitrust exemption.

III.

THE HOLDING OF THE DISTRICT COURT THAT THERE IS NEITHER AN ALLEGATION NOR SHOWING OF "BOYCOTT, COERCION, OR INTIMIDATION" IS UNCHALLENGED AND FULLY SUPPORTED BY THE RECORD

With respect to section 3(b) of the McCarran-Ferguson Act, the District Court correctly held as follows (1979-2 Trade Cas. [CCH] at 78,378, App. B at 33a):

> The complaint does not allege that the defendant's acts constitute "boycott, coercion, or intimidation." Nor do the facts alleged in the complaint fall within the scope of this exception. "The generic concept of boycott refers to a method of pressuring a party with whom one has a dispute by withholding, or enlisting others to withhold, patronage or services from the target." *St. Paul Fire & Marine Ins. Co. v. Barry, supra,* 98 S. Ct. at 2930. Plaintiff does not claim that the defendants have refused to deal with plaintiff's patients. It is not disputed that

> ULL continues to issue policies to plaintiff's patients and to reimburse them for plaintiff's charges to the extent that they are "reasonable" or "not in excess of the regular and customary charges." Nor does the complaint allege that the defendants have induced plaintiff's patients to refuse to patronize plaintiff. . . . Nor do plaintiff's affidavits in opposition to the motion for summary judgment make any factual showing on the issue of boycott.

This holding of the District Court, having been unchallenged upon Pireno's appeal to the Second Circuit, was not considered in the decision of the Second Circuit. Since it is fully supported by the record, the holding of the District Court is dispositive of this issue.

CONCLUSION

For the foregoing reasons, it is respectfully requested that the judgment of the Second Circuit be reversed and the judgment of the District Court dismissing the complaint be directed to be reinstated.

Respectfully submitted,

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Respondent's Brief

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

No 81-389

UNION LABOR LIFE INSURANCE COMPANY, *Petitioner,*

v.

A. ALEXANDER PIRENO, D.C., *Respondent*

No 81-390

NEW YORK STATE CHIROPRACTIC ASSOCIATION, *Petitioner,*

v.

A. ALEXANDER PIRENO, D.C., *Respondent*

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

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BRIEF FOR RESPONDENT A. ALEXANDER PIRENO, D.C.

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QUESTION PRESENTED

Whether an agreement between a professional society and an insurance company to stabilize reimbursement levels through the mechanism of peer review by members of the professional society is immunized from antitrust scrutiny as the "business of insurance" under § 2(b) of the McCarran-Ferguson Act.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

Nos. 81-389 and 81-390

No 81-389

UNION LABOR LIFE INSURANCE COMPANY, *Petitioner,*

v.

A. ALEXANDER PIRENO, D.C., *Respondent*

No 81-390

NEW YORK STATE CHIROPRACTIC ASSOCIATION, *Petitioner,*

v.

A. ALEXANDER PIRENO, D.C., *Respondent*

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

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BRIEF FOR RESPONDENT A. ALEXANDER PIRENO, D.C.

Respondent respectfully prays that the judgment of the United States Court of Appeals for the Second Circuit, entered on May 28, 1981, be affirmed.

STATEMENT OF THE CASE

Peer Review Practices of Petitioners

New York State Chiropractic Association ("NYSCA") established a peer review committee to, *inter alia*, obtain better reimbursement from insurance companies for chiropractors (Brief of Petitioner NYSCA at 3). NYSCA initiated contact with Union Labor Life Insurance Company ("ULL") and other insurers in the early 1970's offering peer review of chiropractors by chiropractors (R. 36, Davis Affidavit, Exh. A.).[1] ULL accepted NYSCA's offer (R.36, Davis Affidavit, Exh. A), as did other commercial insurance companies (R.36, Davis Affidavit at 4). As the September 12, 1974 report of the Chairman of the Peer Review Committee to the NYSCA Board and House of Delegates (R.36, Davis Affidavit, Exhibit E) states: "The peer review committee of ours and every profession was set up to keep 'outsiders' from judging our actions." The report lists as one of the advantages of peer review that "[t]he claim is being evaluated by *a member of one's own profession*", and concluded with the following statement: "My goal is to teach each D.C. how to be so adept at examination and reporting procedure, as well as relating to the carrier that the Peer Review Committee will not have any claims to review from one year to the next." *Id.*

ULL's initial reluctance to utilize NYSCA's committee (R.36, Davis Deposition at 16) was overcome, and it began referring claims for reimbursement to NYSCA.

Respondent has claimed that his fees and/or treatment practices have been reviewed on at least forty occasions, rather than twelve as Petitioner ULL alleges (Brief of Petitioner ULL at 4; *Pireno* v. *New York State Chiropractic Association*, 650 F.2d

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[1] Parenthetical references preceded by "R." refer to the document number of the Index to the Record on Appeal to the Second Circuit.

387, 389 n. 1 (2d Cir. 1981); App. A at 5a).[2] Dr. Pireno has also contended that NYSCA's peer review committee's limitations on the number of reimbursable procedures constitute an effective means of fee-fixing[3] in the chiropractic profession. (R.33, Pireno Deposition at 52).

Petitioner NYSCA states that its "Committee sends its opinion only to the carrier . . . and to the treating chiropractor." (Brief of Petitioner NYSCA at 4). Respondent has contended throughout that the committee's determinations have been provided to his patients; these publications form the basis for his state law defamation cause of action (J.A. at 8a).[4] Thus, while respondent seeks injunctive and declaratory relief pursuant to the antitrust laws, his claim for damages arises under the pendant state claim.

Although petitioner NYSCA asserts that its committee's opinions are advisory only and do not bind any party (Brief of Petitioner NYSCA at 4), respondent has contended that ULL has "limited its payment . . . to the . . . fixed fee" established by the committee. (J.A. at 7a).

Proceedings Below

Respondent addresses petitioner ULL's "Proceedings Below" section in the Argument section of this Brief.

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[2] Parenthetical references preceded by "App." refer to the Appendices to the Petition for Writ of Certiorari.

[3] *See* Havighurst, "Professional Restraints on Innovation in Health Care Financing," 1978 Duke L. J. 303, 381 n. 300 (1978) ("utilization is at least as sensitive an item as price in competitive bargaining in health care, and courts should not hesitate to extend per se concepts to this case").

[4] Parenthetical references preceded by "J. A." refer to the Joint Appendix submitted to the Supreme Court.

SUMMARY OF ARGUMENT

The peer review arrangement between NYSCA and ULL, like the provider contracts in *Group Life and Health Insurance Co.* v. *Royal Drug Co., Inc.*, 440 U.S. 205, 214 (1979), is merely a cost savings "arrangement for the purchase of goods and services," which this court held in that case not to be the "business of insurance" as that term is used in § 2(b) of the McCarran-Ferguson Act. 15 U.S.C. § 1012(b) (1976). Peer review by groups of providers offers an insurance company an alternative to provider contracts as a means of realizing cost reductions in reimbursing its policyholders. The most significant element of peer review, both from a McCarran-Ferguson Act and an antitrust perspective, is that it is conducted by the "peers" of the provider whose claim is being reviewed, that is, by members of his own profession. Peer review has the same relationship to the contract between an insurer and insured as do provider contracts, and the policyholder is no more concerned with the peer review process than he would be with his insurance company's contracts with participating providers. No principled basis exists for distinguishing between these arrangements.

The Second Circuit rejected petitioners' attempt to analogize peer review to intra-industry claims adjustment, as should this Court, on the basis that it involves persons outside the insurance industry. It thus "does not warrant a departure from the analysis compelled by *Royal Drug.*" *Pireno* v. *New York State Chiropractic Association*, 650 F.2d 387, 395; App. A at 18a. The "analysis compelled by *Royal Drug*" focuses on the transfer, underwriting, and spreading of risk. 440 U.S. at 213.

Peer review does not meet the test under *Royal Drug* standards. "Risk" is a term of art in the insurance field, and means, in the health insurance context, the risk that a policyholder will become ill or injured and will be unable to pay for health services. This is the risk the policyholder seeks to insure

against. Peer review does not transfer or spread that risk; it is merely an after-the-fact determination which an insurer may use to reduce its costs in paying for the services received by its policyholders. As such, it is no different from provider contracts or any other business arrangements an insurer might utilize to reduce its costs.

Peer review, futhermore, takes place outside of the relationship between insurance company and insured. This Court has termed that relationship the "focus" of the "business of insurance" exemption. *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969). Neither does peer review relate to the reliability, interpretation, or enforcement of the insurance contract. Members of the peer review committee do not "interpret" the insurance contract; at most, they interpret the provider's bill for services.

New York State's Insurance Law does not regulate NYSCA, peer review committees or procedures, or the arrangement between NYSCA and ULL. The state statutes which petitioners have argued constitute such regulation do not address peer review at all, nor does the state insurance department have jurisdiction over the chiropractic society or its members. A state antitrust statute is insufficient to oust federal antitrust jurisdiction. In order for state regulation to meet the test of § 2(b) of the McCarran-Ferguson Act, and thus exempt the practice in question, it should effectively regulate *that practice* in a clear and affirmative manner.

Finally, the Petitioners' arguments by which they seek exemption on the basis of the "chilling effect" of antitrust scrutiny, and other "policy"-based arguments, are misplaced here. Such arguments must be rejected when weighed against national policy which favors competition and condemns "private regulation", as embodied in the antitrust laws. Exemption from those laws for the "business of insurance", must, as with any other regulated industry, be narrowly construed.

ARGUMENT

I. The Activities Of Peer Review Committees Of Health Care Providers In Evaluating The Procedures And Fees Of Their Competitors Do Not Constitute The "Business Of Insurance" Within The Meaning Of Section 2(b) Of The McCarran-Ferguson Act, And Are Therefore Not Immunized From Antitrust Scrutiny.

The petitioners in this case, NYSCA and ULL, are, respectively, a professional society of chiropractors and an insurance company. These two parties have agreed to an arrangement whereby members of NYSCA, who are practicing chiropractors, perform "peer review" of fees and utilization for chiropractic services which have been submitted as claims for reimbursement by ULL's policyholders. The peer review committee makes "recommendations" as to whether particular fees fall within "customary" or "prevailing" levels of fees and utilization for such services. Based on the information provided by the committee, ULL will then reduce the level of reimbursement it will make to its policyholders for the services they have received, and, in so doing, realize significant cost savings. Respondent submits that this arrangement between NYSCA and ULL is so parallel in purpose and effect to the provider contracts at issue in the *Royal Drug* case that, like those provider contracts, it does not constitute the "business of insurance" as that term is used in § 2(b) of the McCarran-Ferguson Act. 15 U.S.C. § 1012(b).

In *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.*, 440 U.S. 205 (1979), this Court established the principle that an insurer's cost savings "arrangements for the purchase of goods and services" from providers of such goods and services are not the "business of insurance" within the meaning of the McCarran-Ferguson Act's antitrust exemption. *Id.* at 214. Blue Shield's participation contracts with pharmacies were analyzed in that case to determine whether such contracts involved "underwriting or spreading of risk" and whether they related to

the contract "between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement," tests for whether or not an activity constitutes the "business of insurance." *Id.* at 215-16 (quoting *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969)).

The present case also involves an insurer's arrangement with providers, an arrangement which contains the potential for cost savings to the insurer in its purchase of professional services on behalf of its subscribers. Peer review conducted by groups of health care providers is a means, less explicit than but equally effective as participation contracts, whereby a health insurer can reduce, or at least stabilize, its reimbursement costs for such services. The Court of Appeals for the Second Circuit, applying this Court's decision in *Royal Drug*, held that the fee and utilization evaluation activities of peer review committees do not constitute the business of insurance.[5] Peer review, the Court reasoned, neither transfers nor spreads risk, but rather, "like the provider contracts in *Royal Drug*, 'serve[s] only to minimize the costs [the insurer] incurs in fulfilling its underwriting obligations'." *Pireno* v. *New York State Chiropractic Association*, 650 F.2d at 394 (quoting *Royal Drug*, 440 U.S. at 213 (footnote omitted); App. A at 16a. The court also rejected petitioners' arguments that peer review related to "the core of the 'business of insurance'," which was held by this Court in *SEC* v. *National Securities, Inc.*, to include "[t]he relationship between insurer and insured, the type of policy which could be

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[5] *Pireno* v. *New York State Chiropractic Society*, 650 F.2d 387 (2d Cir. 1981). Because the Second Circuit's disposition of these case was on the basis that the violation alleged was not the business of insurance, it did not decide the issue of whether peer review was regulated by state law. Thus, the state regulation component of the McCarran-Ferguson test is not before this Court. Nevertheless, petitioners and their *amici* having raised the issue of regulation of this activity, and given the conceptual relationship between these issues, respondent will address the absence of state regulation of peer review in Part II of this Argument.

issued, its reliability, interpretation, and enforcement." 393 U.S. at 460.

The Second Circuit's decision correctly applied this Court's interpretation of the term "business of insurance," as used in § 2(b) of the McCarran-Ferguson Act, and should therefore be affirmed.

A. The Availability Of Peer Review By Provider Groups Offers Third Party Payors An Alternative To Provider Contracts As A Cost-Reduction Mechanism.

A health insurance company or prepayment plan has a number of alternatives available for the reduction of reimbursement costs. Utilizing its own claims experience, the third party payor might develop a fee schedule for medical procedures and services.[6] Another cost-containment option would be for the insurer to contract directly with health care providers for their services to its subscribers. This option is characteristic of Blue Shield plans, which typically offer "participation" contracts to physicians (and in some cases to other health care providers) under the terms of which the participating provider agrees to accept Blue Shield's payment as payment in full, and not to look to his patient for the balance, should his fee be higher than a fee schedule or the determination of the insurer based on its "UCR" formula.[7] The provider contracts with pharmacies which were at issue in *Royal Drug* present a variation of this mechanism.

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[6] *See* Kallstrom, "Health Care Cost Control by Third Party Payors: Fee Schedules and The Sherman Act," 1978 Duke L. J. 645 (1978).

[7] The term "UCR" refers to the "usual, customary and reasonable" formula adopted by many insurers and prepayment plans. Under this formula, third party payor will pay providers "their 'usual' fee up to a stated percentile of the range of fees that are 'customary' for a particular procedure in the area, with 'reasonable' increases if there are complications." Kallstrom, *supra*, note 2 at 650.

Historically, participating provider contracts have not been utilized by commercial insurers, which generally offer their subscribers indemnity rather than service benefit policies.[8] A commercial insurer such as Union Labor Life which has, for whatever reasons, chosen not to develop and enforce an internal fee schedule for covered procedures,[9] and which does not contract with providers to become participants and thus accept insurer-limited reimbursement, may seek other forms of provider cooperation. Peer review of fees and utilization is one such alternative means for the insurer to deal with providers. Rather than negotiate individual contracts with numerous providers, the insurer agrees, formally or informally, with a provider group (often a subcommittee of a medical, specialty or other professional society), to submit claims to that group for their determination of whether the fee charged or the procedures performed by individual members of their profession comport with prevailing fees and procedures of that profession as a whole.[10]

This arrangement between insurers and provider groups tends, for the most part, to be mutually satisfactory. The insurer is enabled to minimize, or at least stabilize its costs (*Pireno* v. *NYSCA*, 650 F.2d at 393; App. A at 15a-16a), while maintaining a positive relationship with the majority of providers; at the same time, the insurer is able to refer any subscriber complaints

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[8] Two principal types of third party payors have traditionally provided health insurance: Blue Cross/Blue Shield and private commercial insurers. The "Blues" are termed service plans and have been able to contract directly with health care providers for services for their subscribers. Commercial insurers usually do not deal directly with providers, but instead indemnify their subscribers for their medical and hospital bills. *See* Kallstrom, *supra*, note 2 at 649-50.

[9] Brief for Petitioner ULL at 29-30.

[10] *See* M. R. Pollard, R. L. Leibenluft, *Antitrust and the Health Professions* 64-65 (July, 1981).

regarding less-than-full reimbursement to the determination of a committee of "peers" of the subscriber's physician (or other health care provider).

The concept that the members of a review committee are the "peers" of the providers whose fees they evaluate is central to the value of their services to the insurer. The "peer" aspect of peer review also emphasizes the non-"insurance" nature of the committee's function. ULL's arrangement with NYSCA exists precisely *because* the latter's membership is made up of practicing chiropractors; unlike an intra-industry claims adjustor, chiropractors offer their knowledge and skill *as chiropractors* to the insurer. Yet, at the same time, the very fact that the committee's members *are* practicing chiropractors makes them, inevitably, competitors of each other and of the chiropractors whose fees they review. As practicing chiropractors, they are aware of prevailing fees; as members of the state society, they may have access to whatever statistical data regarding fees may have been compiled.

Petitioners have argued that peer review has a more direct relationship to the contract between insurer and insured than the provider contracts at issue in *Royal Drug*, in that the insured is concerned with peer review determinations, which may result in the insured's being reimbursed for less than the full fee which he has paid. Yet, as the Second Circuit's opinion in *Pireno* points out, the effect of the provider contracts in *Royal Drug* "was to require an insured who selected a nonparticipating pharmacy to pay more for drugs than if he had selected a participating pharmacy." 650 F.2d at 394; App. A at 18a. In the present case, as the Court of Appeals analogized, an insured whose chiropractor's charges are deemed higher than UCR "will be required to pay more than if he had consulted one whose charges were 'reasonable' ." The court saw "no meaningful difference between the effect on the insurer-insured relationship in *Royal Drug* and the present case." 650 F.2d at

394; App. A at 18a. Had ULL determined to utilize provider contracts as its mechanism for controlling costs for chiropractic services, Dr. Pireno's position would be that of a nonparticipating chiropractor. ULL has chosen instead to reduce its costs by contracting with the state chiropractic society for its review services, much as the "approved" insurance plans contracted with the Maricopa County FMC. *See State of Arizona* v. *Maricopa County Medical Society*, 643 F.2d 553 (9th Cir. 1980). The insured in each instance finds himself in the same position: if he selects a participating pharmacy or a chiropractor whose charges fall within the norms acceptable to the peer review committe, he will bear no out-of-pocket expenses other than whatever deductible might apply under his policy. If he selects a nonparticipating pharmacy or a higher-priced chiropractor, his reimbursement will be less than his expenses. In both situations, the insurer will have realized a cost saving. As this Court noted in *Royal Drug*, "[t]here is no principled basis upon which a line could rationally be drawn that would extend the McCarran-Ferguson Act exemption only to an insurer's agreement with providers of goods and services to be furnished to its policyholders — such as agreements with hospitals, doctors, lawyers and the like." 440 U.S. at 232, note 40. An insurer's agreement with a *group* of providers should be accorded the same McCarran-Ferguson Act status as individual provider agreements, especially where, as here, the ultimate effect — cost savings to the insurer — is the same.

There is, moreover, "no principled basis" upon which an insurer's agreements with *individual* providers could be held *not* to be the "business of insurance", while its agreement with a group of providers, or an entire professional society is immunized. Such a distinction would enable insurers and providers to evade antitrust scrutiny merely by the device of the providers' having acted as a group in their dealings with an insurer, a result inimical to both the language and spirit of the Sherman Act, and surely not a result intended by Congress in the McCarran-

Ferguson Act. If individual provider agreements are subject to the antitrust laws, the agreements of a professional society of providers must also be subject to those laws.

B. The Issue Of Whether Intra-Industry Claims Adjustment Procedures Are Part Of The "Business Of Insurance" Need Not Be Reached In Order To Affirm The Second Circuit's Decision.

Petitioner ULL argues, as it did before the Second Circuit, that peer review should be analogized to claims adjusting and claims settlement processes rather than to provider contracts. (Brief of Petitioner ULL at 20-24.) The entire thrust of petitioners' argument is premised upon this analogy, for they proceed to argue that *claims adjusting* is part of the "business of insurance" in relation both to risk-transfer and spreading, as well as to the contract between insurer and insured. [11] Yet, the Second Circuit never held that claim adjustment was or was not part of the "business of insurance"; the court's observation regarding claims adjustment itself was *dicta* ("it is by no means clear that claim-settlement itself constitutes 'the business of insurance' " 650 F.2d at 394; App. A at 18a), for the court went on to conclude that the peer review committee consists of "persons outside the [insurance] industry" and that "the *resemblance* of peer review to intra-industry claims adjusting does not warrant a departure from the analysis compelled by *Royal Drug*." (footnote omitted, emphasis added). 650 F.2d at 395; App. A at 18a. This conclusion avoided any necessity for the Second

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[11] At the time this suit was filed, however, ULL did not appear to consider NYSCA's peer review procedures an integral part of its own claims settlement process for, in its Answer to Dr. Pireno's Complaint, the insurer cross-claimed against NYSCA, contending that:

> If plaintiff recovers a judgment against defendant Union, such liability will have been brought about and caused solely by reason of the actions of defendants New York State Chiropractic Association and International Chiropractic Association. (J.A. at 14a, ¶ 24).

The International Chiropractic Association was dismissed with prejudice pursuant to stipulation. 650 F.2d at 389-90, note 4; App. A at 7a, note 4.

Circuit to determine the exemption status of intra-industry claims adjusting; it was simply a rejection of petitioner's analogy.

The focus of respondent's complaint was not upon the internal claims settlement processes of ULL or of the insurance industry in general, but rather, only upon the joint activities of NYSCA's peer review committee and ULL (J.A. at 4a-9a). Had, in fact, the determinations regarding respondent's fees and reimbursement been solely the product of ULL's internal claims settlement mechanisms, respondent would not have initiated this litigation under Section 1 of the Sherman Act, 15 U.S.C. § 1, for the internal decision-making processes of a corporation as to the price it will pay for goods and services is not usually the result of a "contract, combination or conspiracy in restraint of trade." It is only when the insurer, as ULL did here, looks to providers or other parties *outside* the insurance industry (or, in another context, combines with other insurers in ways not protected by the McCarran-Ferguson Act) that Section One violations may be said to arise. Thus, petitioners' arguments defending the need for and exempted status of claims settlement procedures miss the point: when an insurer chooses to go outside of the typical intra-industry structure to contract with providers in order to minimize its liability for claims made against it, it loses the protection from antitrust scrutiny that its actions would have had if they had occurred entirely within the insurance industry. This does not mean that its actions are automatically viewed as antitrust violations. It merely assures that antitrust scrutiny is available to police unregulated non-insurance-related agreements between insurers and provider entities, as well as the actions of those entities in fulfilling their agreements with insurers. The agreement between ULL and NYSCA is an agreement between an insurer and a group of providers whereby the latter has contracted to perform a service which is intended to contain the insurer's costs of meeting its obligations to its policy holders, analogous to the participating pharmacy agreements at issue in *Royal Drug*.

C. An Insurer's Arrangement With Providers Whereby The Latter Perform Peer Review Of Other Providers' Fees And Procedures Neither Transfers Nor Spreads The Risk That Subscribers Will Require The Providers' Services.

The Second Circuit defined the risk which has been assumed and underwritten by ULL in its contracts of insurance with its subscribers as "[t]he risk that an insured will require chiropractic treatment." 650 F.2d at 393; App. A at 14a. That risk, the Second Circuit held, "has been transferred from the insured to the insurer by the very purchase of insurance." *Id.*; App. A at 15a. The court reasoned that "[p]eer review takes place only after the risk has been transferred by means of the policy, and then it functions only to determine whether the risk of the entire loss . . . has been transferred to the insurer. . . . At most, [peer review] is an aid in determining the scope of the transfer after it has been made." *Id.*

This line of reasoning is similar to that followed by the district court in *State of Arizona* v. *Maricopa County Medical Society*, 1979-1 Trade Cases (CCH) ¶ 62,694 (D. Ariz. 1979) *aff'd.*, 643 F.2d 553 (9th Cir. 1980), *cert. granted*, 101 S. Ct. 1512 (1981).

Maricopa County involved the State of Arizona's antitrust challenge to a system whereby a group of physicians, who were members of a foundation for medical care which administered several private insurers' health care plans, agreed upon the maximum fees reimbursable by those insurers who were "approved" members of the plan. This arrangement was held by the district court not to constitute the "business of insurance", not so much because it did not underwrite *any* risk, but because the risk underwritten was not one *peculiar to* the "business of insurance". Although the provider agreement in *Maricopa County* might relate to an insurer's business risk (that the cost of providing health services to subscribers would be more than the maximum amounts the participating physicians would receive),

it did so in the same manner by which "every contract for the sale of goods and services protects the parties against future fluctuations in the market price. Such an underwriting of risk is not peculiar to the business of insurance." 1979-1 Trade Cases at 77,894. The type of risk "peculiar to the 'business of insurance,'" on the other hand,

> is the risk that policyholders cannot afford the services of a physician when needed. The participating insurance companies underwrite or assume this risk in return for the payment of premiums. . . . Merely because an insurance company acts to reduce the risk that it has underwritten does not directly further underwrite or spread the risk that the policyholders sought to insure against. . . . The obligation that the participating insurance companies have incurred remains constant. How they go about satisfying that obligation does not involve the business of insurance since a reduction in liability and thus the risk they have assumed does not change the risk against which the policyholder obtained insurance. *Id.* at 77,894.

The insurer's obligation to its insured and the risk it has underwritten in the policy are thus not affected by the means an insurer employs to meet obligations, whether those means are in the form of provider contracts or peer review. [12]

The Arizona district court's reasoning applies fully to this case. Whether peer review is characterized as "an aid in determining the scope of the transfer after it has been made" (650 F.2d at 393; App. A at 15a), or "a device which helps implement and make meaningful the underwriting, risk-spreading and risk transfer decisions reflected in an insurance policy,"

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[12] The Maricopa FMC, in fact, used peer review processes as a means for policing its physician-approved "maximum" fee schedules. 1979-1 Trade Cases at 77,895. The existence of peer review did not change the district court's view of the provider agreement as not the "business of insurance". The court's McCarran-Ferguson Act determination was not at issue in Arizona's petition for certiorari to this Court.

(Brief of Petitioner ULL at 17-18), the fact remains that peer review does not occur until sometime after the transference and spreading of risk have already been effectuated, at a time when the insurer's interests are focused on minimizing its liability to its insured, who is claiming against the policy that transferred the risk originally. An after-the-fact determination by peer review of the exact amount of payment for which ULL is liable to its policyholder has not changed the risk ULL originally assumed that the policyholder would require the services. If, by the term "risk", petitioners mean the "risk" to which ULL is exposed in meeting its obligations, that, as the Arizona district court would say, is a *business* risk, not a business of insurance risk, which ULL is certainly entitled to try to reduce, but such reduction is not thereby exempted from antitrust scrutiny. Once it is recognized that the insurer's interest in using peer review lies in reducing the extent of its exposure in satisfying claims (the same interest which motivates an insurer to enter into participating provider contracts), the lack of a principled basis for distinguishing between the two mechanisms become apparent.

Peer review, like provider contracts, enables ULL "to minimize costs and maximize profits." 440 U.S. at 214. Utilizing peer review, as this Court observed in *Royal Drug* about the practice at issue there, "may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but [it is] not the 'business of insurance'." *Id.* (footnote omitted). However beneficial ULL may find its cost savings arrangement with NYSCA, its decision to utilize peer review must be considered only "the business of [an] insurance compan[y]" not the business of insurance. *Id.* at 233.

Petitioner ULL attempts to distinguish peer review from the pharmacy agreements in *Royal Drug*, by claiming that peer review does not always result in reduced costs to the insurer. At

times, the committee's determinations, ULL points out, "result in full reimbursement of a policyholder's claim that otherwise would not have been paid." (Brief of Petitioner ULL at 19). It is rather disingenuous for ULL to argue that the occasional failure of its chosen cost-reduction mechanism to achieve its intended result changes in any way the nature or focus of the peer review committee's activities or ULL's underlying interest in the arrangement.

ULL's aggregate cost of reimbursing its insured must surely be lowered by peer review (even factoring in whatever administrative expenses may be associated with it) from the level they would be without peer review, or else ULL, as a rational business, would discontinue the arrangement. [13]

ULL further argues that the Second Circuit made the aspect of cost reduction the touchstone of whether or not a practice is within the "business of insurance", and then responds to its own misinterpretation of that court's reasoning by claiming that "it does not follow that if a practice tends to reduce costs, it is, for this reason, outside the 'business of insurance'." ULL then concludes that:

> most provisions that can be characterized as underwriting, risk-spreading or risk transfer are designed to reduce costs. This is the obvious function served by such typical insurance contract provisions as coverage deductibles, underwriting exclusions, co-insurance factors and risk limita-

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[13] The Second Circuit noted that peer review might not greatly lower an insurer's costs, "for committee members' self interest may cause them to set the 'usual' rate above prices that would otherwise obtain in the market. Nonetheless, the inevitable effect of peer review would seem to be stabilization of prices and mitigation of future price increases, provided that insurers actually follow the committee's recommendations." 650 F.2d at 394, note 11; App. A at 16a.

tions. Brief of Petitioner ULL at 18-19. (Footnote omitted).

What ULL fails to acknowledge in this argument is that the Second Circuit first found that peer review *did not* transfer or spread risk before it held the practice to be "simply a form of cost reduction." 650 F.2d at 393; App. A at 15a. The court never held that cost-reduction itself was antithetical to risk transfer or spreading. Furthermore, ULL's examples of cost-reducing insurance contract provisions all reflect limitations on liability that are included *in the policy* which itself transferred the risk from the policyholder, and that do not look to the services of persons outside the industry for their cost reduction effect. Where, on the other hand, an insurer has contracted with providers with regard to costs associated with services to its insured, analysis under *Royal Drug* standards requires a determination of whether something more than cost reduction is involved, that is, whether risk-spreading or transfer has been effectuated by means of the insurer's arrangements with providers, or whether they are indistinguishable from "countless other business arrangements that may be made by insurance companies to keep their costs low and thereby also keeping low the level of premiums charged to their policyholders." 440 U.S. at 215. The Second Circuit correctly held that peer review was within the latter category.

D. Peer Review Is Not Within The "Core" Of State-Regulated "Business of Insurance".

In *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969), this Court held that, in enacting the McCarran-Ferguson Act,

> Congress was concerned with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation and enforcement — these were the core of the 'business of insurance'. . . . Statutes aimed at protecting or regulating

> this relationship, directly or indirectly, are laws regulating the 'business of insurance'. 393 U.S. at 460.

The above-quoted language was interpreted in *Royal Drug* to exclude the participation agreements between Blue Shield and the pharmacies. This Court held that such agreements were not "between insurer and insured", but rather were "separate contractual arrangements between" the insurer and persons "engaged in the sale and distribution of goods and services other than insurance." 440 U.S. at 216. The present case also involves a separate contractual arrangement between ULL and NYSCA. Even though their agreement is not embodied in a formal document, an informal contractual undertaking exists whereby NYSCA performs peer review services for ULL and ULL avails itself of those services, and forebears from utilizing the peer review services of medical doctors for chiropractic claims. Brief of Petitioner NYSCA at 3-4; R. 36, Davis Affidavit at 3-4.

Thus, as petitioners frankly admit, NYSCA and ULL are parties to a mutually beneficial contractual relationship. Brief of Petitioner NYSCA at 3-4; Brief of Petitioner ULL at 3-6. ULL's insureds are not parties to this agreement. The members of NYSCA, and its peer review committee, are practicing chiropractors, engaged in the sale and distribution of chiropractic services, and, it may be assumed, have patients who are insured by ULL and other third party payors which utilize NYSCA's peer review services. Peer review is thus, like the *Royal Drug* provider contracts, a separate contractual arrangement between ULL and NYSCA, acting for its members who are practicing chiropractors. ULL's policyholders, like Blue Shield's policyholders in *Royal Drug*, are "basically unconcerned with arrangements made between" their insurer and providers. 440 U.S. at 214. The Second Circuit analogized policyholder's respective positions with relation to the participation agreements in *Royal Drug* and to peer review, and found "no meaningful difference between the effects on the

insurer-insured relationship between *Royal Drug* and the present case." 650 F.2d at 394; App. A at 18a. Provider contracts "required any insured who selected a nonparticipating pharmacy to pay more for drugs than if he had selected a participating pharmacy," whereas, in the instant case, "an insured who consults an unreasonably expensive chiropractor will be required to pay more than if he had consulted one whose charges were 'reasonable'."[14] 650 F.2d at 394, App. A at 18a. The "expensive" chiropractor, in the peer review context, may be viewed as a "nonparticipant" and his patient's position is no different from that of a subscriber who purchases drugs from a nonparticipating pharmacy. If the latter is "basically unconcerned" with his insurer's contractual arrangements with providers, so too is the ULL subscriber, who is also Dr. Pireno's patient, "basically unconcerned" with the existence of a peer review mechanism.

In fact, if distinctions are to be drawn, peer review peformed at the request of a commercial insurer is even less related to the insurer-insured relationship than the provider agreements in *Royal Drug*, for in the latter case the insurer was a Blue Shield plan whose policies provided for service benefits rather than cash reimbursement. Thus, as the dissenting opinion in *Royal Drug* pointed out, Blue Shield obligated itself to pay its policyholders in services, and its contracts with providers were "direct arrangement[s] to provide the very goods and services whose purchase is the risk assumed by the insurance company." 440 U.S. at 250 (Brennan, J., *dissenting*). A commercial insurer's use of peer review is located even further outside the "business of insurance" than such provider contracts.

Petitioners also argue that peer review relates to the reliability, interpretation and enforcement of the insurance contract,

---

[14] The terms "unreasonable" and "reasonable" are terms of art which reflect the committee determinations under UCR standards, rather than any objective determination that an expensive chiropractor is unreasonably so.

and attempt to distinguish peer review from the *Royal Drug* provider contracts on that basis. Yet, as this Court pointed out in *Royal Drug*, "every business decision made by an insurance company has some impact on its reliability as an insurer." 440 U.S. at 216-217. ULL's "status as a reliable insurer" is no more affected by peer review's cost-limiting effects than Blue Shield's status was by the cost reduction inherent in its provider agreements.

Petitioners further argue that peer review is distinguishable from provider contracts in that it "interprets" the insurance contract by ascertaining whether or not a fee or procedure "is within the scope of the risks covered by the policy terms." Brief of Petitioner ULL at 13. Petitioners' characterization of what peer review actually does is somewhat grandiose. The members of NYSCA's committee are chiropractors, whose function is less one of interpreting the insurance contract than it is of "filling in the blanks". ULL already knows what its own policies mean by the terms "usual", "customary" and "reasonable"; the information it seeks from NYSCA is the dollar figure which represents prevailing fees for the procedure that has been performed. Peer review committee members are valuable to the insurer because they know what was involved in the procedures that were performed and they know how much they and their colleagues charge for such services. If anything is "interpreted" by a peer review committee, it is the provider's bill. In like manner, committee members hardly "enforce" the insurance contract. As strangers to the policy between insurer and insured, they are in no position either to make a claim under that policy or to refuse payment in the name of the insurer. And, to the extent that they may be said to play an advisory role to the insurer in paying claims, they do so as providers and not as members of the insurance industry. In fact, as Judge Hall pointed out in his dissent in *Bartholomew* v. *Virginia Chiropractors Association*, 612 F.2d 812, 818-819 (4th Cir. 1979) (Hall, J., *concurring in part and dissenting in part*), providers

may abuse this advisory role, utilizing peer review as a means for enforcing a professional association's fee schedule, and then attempt to shelter this activity under the insurer's antitrust immunity.

The impetus for peer review, at least in this case if not generally, came from the providers, who offered the peer review arrangement to ULL, which agreed to utilize their services. The dissent in *Royal Drug* noted that not "*all* provider agreements come within the McCarran-Ferguson Act *proviso*." *Royal Drug*, the dissent stated, was "not a case where the petitioner pharmacies themselves conspired to exclude others from the market, and either pressured Blue Shield to go along or were voluntarily joined by the insurer. Such an agreement . . . would be outside the 'business of insurance'." 440 U.S. at 253 (Brennan, J., *dissenting*) (emphasis added). The agreements alleged here, first among the members of NYSCA and its peer review committee, and then between NYSCA and ULL, *are* "such an agreement". Here both the "perpetrators and the impact of the conduct" at issue arise outside the insurance industry. *Hoffman* v. *Delta Dental Plan of Minnesota*, 517 F.Supp, 564, 569 (D. Minn. 1981) (*citing dissent in Bartholomew*).

Thus, whatever advisory role NYSCA's peer review committee may have assumed, and whatever reliance ULL may place upon its determinations, do not change the fact that the peer review mechanism was originated and is carried on by persons outside the insurance industry. Those persons were and remain competitors of each other and of the providers whose claims they review. The potential for antitrust abuse is great whenever competitors possess, or have been accorded, some degree of authority to determine price levels in their own trade or profession. By enlisting ULL and other insurers in its efforts, NYSCA has placed itself in a position from which it seeks to immunize its activities from antitrust scrutiny under the

McCarran-Ferguson Act's umbrella. But an exempt entity "cannot immunize an illegal conspiracy by joining it." *Royal Drug*, 440 U.S. at 253 (Brennan, J., *dissenting*) (*comparing Parker* v. *Brown*, 317 U.S. 341, 351-352). In analogous contexts, the exempt entity is more likely to lose its own immunity in such circumstances rather than confer it on others. *Id.* Peer review by provider entities inescapably falls outside the insurer-insured relationship, and therefore should not be immunized.

II. Neither The Peer Review Activities Of NYSCA Nor The Arrangement Between NYSCA And ULL Is Regulated By State Law To The Extent Required For Exemption Under Section 2(b) Of The McCarran-Ferguson Act.

Traditionally, a two-stage test has developed for determining the antitrust exemption status of actions of insurance companies and others who claim immunity under § 2(b) of the McCarran-Ferguson Act. *See* Weller, "The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy," 1978 Duke L.J. at 602, 614 (1978). Courts first look to whether the activity is the "business of insurance". Only if it is found to be the "business of insurance" do they then consider the second stage, the extent to which the activity is regulated by state law. (A third test, which is contained in § 3(b) of the Act, requires the court to decide whether state-regulated "business of insurance" activity nevertheless constitutes "an act of boycott, coercion, or intimidation," and is not at issue here). Since the Second Circuit reversed the district court's decision in the present case on the basis of the first test, holding peer review *not* the "business of insurance", it was unnecessary for it to decide the extent to which the practice is regulated by New York State law. Respondent raises this issue here in part to respond to the arguments of petitioner ULL and some of the *amici* who support petitioner's position, and in part to emphasize independently the total lack of regulation or supervision of peer review arrangements and procedures by the New York State Insurance Department.

Several commentators have raised an issue regarding how "effective" state regulation must be to meet this test. The Weller article notes that, while "[l]ower courts have generally held that mere regulatory legislation is sufficient," commentators have urged an "effective" regulation test, similar to that applied in "antitrust litigation involving regulatory agencies." Weller, 1978 Duke L.J., *supra*, at 606-607, note 96.

This court had occasion to rule on this issue in *FTC* v. *National Casualty Co.*, 357 U.S. 560 (1958), where it held that state insurance statutes prohibiting unfair and deceptive practices were not superseded by § 5 of the FTC Act. *Id.* at 564. That case should, however, be distinguished from the present situation, for *National Casualty* involved the FTC's "unfair and deceptive acts and practices" jurisdiction not its antitrust jurisdiction. Arugably, the latter field is more complicated than false advertising and requires more direct and effective regulation. Weller, 1978 Duke L.J., *supra*, at 606, note 96. Furthermore, the present case involves a total absence of state insurance department regulatory authority or supervision over NYSCA or over the business arrangements between NYSCA and ULL. As Weller points out, "[s]ome of the most novel and difficult of these questions [of *proviso* clause interpretation] arise in the context of insurance arrangements having a substantial impact on industries outside insurance, such as automobile repair shops, hospitals, doctors, pharmacists and dentists." *Id.* at 607. The article argues that these difficulties can be resolved by strict application of the "to the extent that" language of the *proviso* in order to "avoid any gap" between federal and state law "and to require specific state regulatory authority over the activity in question before McCarran Act immunity would exist" (citation omitted). *Id.* The article cites a 1948 article written by Senator McCarran which supports this interpretation:

> State regulation . . . to constitute an effective assertion of jurisdiction, probably would have to meet certain mini-

> mum standards. *The State law should be explicit with respect to the practice which it is sought to regulate.* Probably also the State law should be prohibitory rather than permissive. That is, it should prohibit *the particular practice* except in accordance with specified procedure and subject to State approval, rather than simply permitting the practice in question. *Id.* at 608 (citing McCarran, "Federal Control of Insurance: Moratorium Under Public Law 15 Expired July 1," 34 A.B.A.J. 539, 542 (1948) (emphasis added).

In *St. Paul Fire & Marine Ins. Co.* v. *Barry*, 438 U.S. 531 (1978), this Court found it significant that the boycott conduct with which the four insurers were charged "occurred *outside of any regulatory or cooperative arrangement established by the laws of Rhode Island.* There was no state authorization of the conduct in question . . . and petitioners do not aver that state law or regulatory policy can be said to have *required* or *authorized* the concerted refusal to deal with St. Paul's customers." 438 U.S. at 553-554 (footnote omitted; emphasis added).

ULL claims that its practices are extensively regulated by New York State, yet is able to cite no state statute or regulation which is explicit with respect to the practice of peer review. In fact, New York State's insurance laws and regulations are silent with respect to the activities of peer review committees themselves and the specific contractual arrangements between insurers and such committees. They are silent for good reason, for the Insurance Department lacks jurisdiction over non-insurance parties (Art. IX-D N.Y. Ins. Law § 271 [McKinney 1966 & Supp. 1981]), such as chiropractors and their professional associations. Petitioner's analogy of peer review to claims adjustment must fail on this ground also, for § 123 of New York's Insurance Law prohibits anyone except those licensed to do so under that section from acting as an "adjustor" for insurance purposes. The Second Circuit observed that:

> defendant NYSCA itself does not appear to be regulated by state law *in the manner § 2(b) requires.* Although

> N.Y.S. Ins. Law § 271 (McKinney 1966) brings 'corporation[s] . . . engaged in the business of insurance' within the jurisdiction of state insurance authorities, the statute was fairly clearly drafted with the focus on corporations in the insurance industry. The fact that NYSCA is a corporation that advises an insurer as to the reasonableness of chiropractic fees makes it no more a member of the insurance industry than would be a financial consultant who advises an insurer on the prudent investment of its reserves. 650 F.2d at 390, note 5; App. A at 8a, note 5 (emphasis added).

ULL also points to its regulation under New York State's antitrust statute, the Donnelly Act (N.Y. Gen. Bus. Law § 340 [McKinney 1968 & Supp. 1981]). However, "[n]ot all state laws are relevant in determining McCarran Act immunity; the only pertinent state laws are those 'enacted for the purpose of regulating the business of insurance.' *SEC* v. *National Sec., Inc.*, 393 U.S. 453, 457 (1969)." Weller, 1978 Duke L.J., *supra* at 602, note 77. Mere inclusion of insurance companies within the jurisdiction of a state's antitrust statute is not enough to oust federal antitrust jurisdiction over an insurance company's activities. *See* Weller, "To Preempt or to Accommodate: The Question of State and Federal Antitrust Laws Under the McCarran-Ferguson Act," 9 Tol. L. Rev. 421 (1978) (which reaches the conclusion that state antitrust laws do not meet McCarran Act standards for immunity).

Furthermore, NYSCA and the members of its peer review committee are not subject to the Donnelly Act, which has been held not to apply to professionals and their professional associations. *In re Estate of Freeman*, 34 N.Y 2d 1, 311 N.E. 2d 480, 355 N.Y.S. 2d 336 (1974). Thus, if Dr. Pireno is deprived of a federal forum for his complaint on the basis that peer review members are engaged in the "business of insurance . . . regulated by state law," that state's law will operate to deny him a state court forum, at least with respect to NYSCA and the members of its peer review committee.

Weller's article suggests that the state action exemption doctrine of *Parker* v. *Brown*, 317 U.S. 341 (1945) and its progeny supplies a rationale for determining the extent of state insurance regulation, in that both "*Parker* and the McCarran Act antitrust exemptions are analogous since both are premised on state regulation and both deal with delicate problems of federalism (footnote omitted)." 1978 Duke L.J. at 615. This Court's recent application of the *Parker* doctrine in *Community Communications Co.* v. *City of Boulder*, ____ U.S. ____ , 50 U.S.L.W. 4144 (1982) re-affirms the principle that exemption from antitrust scrutiny requires a "clearly articulated and affirmatively expressed state policy" to displace competition with state regulation. *Id.* at 4146. Whatever determinations the New York State legislature may have made regarding competition among insurers, it cannot be said to have "clearly articulated" or "affirmatively expressed" a state policy to regulate the activities of chiropractors or other professionals under the State's insurance law.

The National Association of Insurance Commissioners ("NAIC"), in its *amicus* brief, argues that New York State law "requires" ULL to use peer review procedures. The rather strained basis for this assertion is that New York's unfair trade practice laws, which govern claims settlement practices, "are patterned after the NAIC's Model Trade Practices Act, which, among other provisions, requires insurance companies to conduct 'a reasonable investigation based upon all available information' before paying insurance claims." Brief Amicus Curiae of NAIC at 21-22. (footnote omitted). This assertion must fail: it would require this Court to accept the proposition that a requirement for the *insurance company* to investigate claims implies a *requirement* that the company use peer review as the investigative means. Furthermore, NAIC only asserts that its Model Act, rather that New York State law, requires such an investigation. Such an attenuated, imprecise statutory

directive hardly meets the test that state policy be "clearly articulated" and "affirmatively expressed".

Finally, petitioners and their *amici* point to the availability of complaint mechanisms within New York State's Insurance Department to handle the complaints of Dr. Pireno and/or his patients regarding ULL's claims settlement practices and suggest that he and they failed to bring these matters to the Department's attention. Brief of Petitioner ULL at 26, 32; Brief of NAIC at 22. There is nothing in the record of this case which suggests that either respondent or his patients failed to pursue this route. Dr. Pireno has, in fact, testified that he recommended that his patients contact the New York State Insurance Department regarding ULL's use of peer review. R. 44, Pireno Deposition at 12-14. The effectiveness of taking such action, however, is questionable. A recent report to the Congress by the Comptroller General of the United States on state regulation of insurance concluded, after a survey and investigation of the functioning of several state insurance departments, including that of New York State, that:

> There was no evidence in most states that there are implemented in the examination process itself qualitative standards of what constitutes unacceptable behavior by insurance companies. . . .
>
> [T]he problem is that most insurance departments do not have adequate information on the nature and extent of existing problems. Without systematic information these insurance departments *cannot regulate as effectively as they should*. Comptroller General, *Report to Congress: Issues and Needed Improvements in State Regulation of Insurance Business* (U.S. General Accounting Office) 57 (Oct. 9, 1979) (emphasis added).

The Report also noted that "[a]lthough all states had unfair trade practices laws, none of the market conduct examinations explained what the minimum standards were or even if such

standards were used in assessing company performance." (*Id.*, Digest at iii). [15]

Thus, substantial questions exist regarding the degree of "effectiveness" of the very unfair trade practices laws and procedures the NAIC would have this Court find to be the type of state regulation which ousts any opportunity for antitrust scrutiny of peer review.

III. The "Policy"-Related Arguments of Petitioners And *Amici* Supporting Their Position Are Outweighed By The Procompetitive Policies Of The Sherman Act.

Petitioners ULL and NYSCA both urge this Court to grant the McCarran-Ferguson Act's shield from antitrust scrutiny to peer review because of the "chilling effect" antitrust suits may have on this practice. Brief of Petitioner ULL at 28-30; Brief of Petitioner NYSCA at 6-7. But this Court has consistently refused to entertain pleas for antitrust exemption which are predicated upon the basis that application of the antitrust laws will be harmful to an industry, profession, or other entity. In the *South-Eastern Underwriters Association* case itself such arguments were advanced. Quoting from the opinion of Justice Harlan in *Northern Securities* v. *United States*, 193 U.S. 197, 351-352 (1904), this Court responded:

> It is the history of monopolies in this country . . . that predictions of ruin are habitually made by them when it is attempted, by legislation, to restrain their operations and to protect the public against their exactions. . . .
>
> But even if the court shared the gloomy forebodings in which the defendants indulge, it could not refuse to respect the action of the legislative branch of the government. . . .

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[15] The Report also devotes an entire chapter to the problems of regulatory independence, the "revolving door" syndrome as it exists in state insurance departments, and allegations of industry dominance of the NAIC itself. *See Id.*, Chapter 8.

> The suggestions of disaster to business have, we apprehend, their origin in the zeal of parties who are opposed to the policy underlying the act of Congress or are interested in the result of this particular case; at any rate, the suggestions imply that the court may and ought to refuse the enforcement of the provisions of the act if, in its judgment, Congress was not wise in prescribing as a rule . . . that every combination, whatever its form, in restraint of [interstate] commerce . . . shall be illegal. These, plainly, are questions as to the policy of legislation which belong to another department, and this court has no function to supervise such legislation from the standpoint of wisdom or policy. . . . *U.S.* v. *South-Eastern Underwriters Assn.*, 322 U.S. 533, 561-562 (1944) *(citation omitted*).

This standard was again articulated in this Court's recent decision in *Community Communications Co.* v. *City of Boulder*. The Court responded to the City of Boulder's argument "that denial of the *Parker* exemption . . . will have serious adverse consequences for cities" by observing that "this argument is simply an attack upon the wisdom of the long-standing congressional commitment to the policy of free markets and open competition embodied in the antitrust laws." 50 U.S.L.W. at 4148 (footnote ommited). *See also National Society of Professionals Engineers* v. *United States*, 435 U.S. 679, 695 (1978) ("petitioner's attempt [to justify its restraint on competitive bidding] on the basis of the potential threat competition poses to the public safety and the ethics of its profession is nothing less than a frontal assault on the basic policy of the Sherman Act.")

Since this Court's decision in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), members of the "learned professions" have learned the necessity of conducting their business in accordance with the antitrust laws, just as the vast majority of American industries and businesses must do. If members of peer review committees are unsure of the result of trials on the

merits of antitrust cases brought against them, they are certainly entitled to discontinue their operations in the future. But threats and "gloomy forebodings" are an insufficient basis for an antitrust exemption unless it has been provided by the legislature. What Congress has provided is an exemption for "the business of insurance to the extent it is regulated by state law". If peer review does not meet this test, as respondent submits it does not, then it is not exempt, and "policy" arguments are best directed to the Congress, not to this Court.

Amici curiae, the Health Insurance Association of America ("HIAA") and the American Council of Life Insurance ("ACLI"), argue that the federal government has recognized the value and importance of peer review by its authorization of professional standard review organizations ("PSRO's") for professional review of Medicare and Medicaid claims. Brief *amicus curiae* of HIAA and ACLI at 12-13. Yet, the statute which provided for establishment of PSRO's limits their responsibilities to "appropriateness and quality" of care review. P.L. 92-603, 42 U.S.C. § 1320c *et seq*. PSRO's are not authorized to review individual fees or to establish fee levels. Furthermore, a recent Congressional Budget Office study of these entities has questioned their effectiveness. Congressional Budget Office, *The Effects of PSRO's on Health Care Costs* (1979). The federal government has been reported to be in the process of terminating 46 of the country's 187 PSRO's, and to have plans to abolish all of them within the next two years. "3 Medical Study Units in Area to Lose Funds," *Washington Post* A1, A30 (November 5, 1981).

The type of peer review of fees and procedures at issue here, that conducted by private groups of professionals in concert with private insurance companies, has never been authorized by federal legislation any more than it is required or regulated by state legislation. Peer review is precisely the sort of private regulation of trade and commerce which Congress has made

subject to the antitrust laws and which the McCarran-Ferguson Act does not exempt. One of the Senatorial supporters of the conference committee report on S.340 (the original text of the McCarran-Ferguson Bill), set forth the view that "regulation by private combinations and groups" is "harmful to the public interest," and "would be absolutely outlawed should the conference report be adopted." 91 Cong. Rec. 1483 (remarks of Sen. O'Mahoney).

Whether or not private regulation through peer review should be "absolutely outlawed" or judged under Rule of Reason standards is an issue that goes to the substantive merits of this case and, thus, is not before the Court at this time. Neither is the efficacy, usefulness, or convenience of peer review to ULL and other insurers at issue here. All this Court is presently called upon to determine is whether the antitrust laws are available to determine when and if there has been an anticompetitive abuse of the peer review process in a particular situation. If not, private regulation of this type will continue to be unscrutinized and shielded from the antitrust laws merely because a group of competitors is able to persuade one or more insurance companies to participate in their activities. *See Bartholomew* v. *Virginia Chiropractors Association, supra,* 612 F.2d at 819 (Hall, J., *dissenting*). As this Court re-iterated in *Royal Drug,* "[i]t is well settled that exemptions from the antitrust laws are to be narrowly construed." 440 U.S. at 231 (citations omitted). Furthermore, as this Court also noted in that case, "[i]n analogous contexts, . . . an exempt entity forfeits antitrust exemption by acting in concert with nonexempt parties." *Id.* (citations omitted). These fundamental principles of antitrust law apply with equal force here, where both the impetus for private regulation arose outside the insurance industry and where the impact of that private regulation is primarily felt outside that industry. The McCarran-Ferguson Act's exemption is narrowly limited to state-regulated "business of insurance". It does not protect private business arrangements between insurance com-

panies and non-insurance parties. Arguments which seek antitrust exemption for private regulation on the basis of either the business convenience of the parties or the claimed benefits of the practice are misplaced.

CONCLUSION

For the foregoing reasons, it is respectfully requested that the judgment of the Second Circuit be affirmed and the case remanded to the District Court for the Southern District of New York for further proceedings.

Respectfully submitted,

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Petitioner's Reply Brief

Nos. 81-389, 81-390

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY,

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—v.—

A. ALEXANDER PIRENO,

Respondent.

NEW YORK STATE CHIROPRACTIC ASSOCIATION,

Petitioner,

—v.—

A. ALEXANDER PIRENO,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY BRIEF FOR PETITIONER UNION LABOR LIFE INSURANCE COMPANY

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REPLY BRIEF FOR PETITIONER UNION LABOR LIFE INSURANCE COMPANY

Petitioner respectfully submits this brief in reply to the Brief for Respondent A. Alexander Pireno and the briefs for amici supporting affirmance.

I.

THE CHALLENGED ACTIVITY IS PART OF THE BUSINESS OF INSURANCE

Respondent and amici supporting affirmance[1] urge this Court to extend its holding in *Royal Drug*[2] so as to place the challenged activity in this case beyond the pale of the explicit federal antitrust exemption provided by the McCarran-Ferguson Act. In so doing, they would perpetuate the error of the Second Circuit which saw "no meaningful difference"[3] between the pharmacy agreements in *Royal Drug* and the peer

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1 Among the amici briefs supporting affirmance is a Brief for the United States as Amicus Curiae filed by the Justice Department ("Justice Dep't Br."). It is noteworthy that Congress historically has not agreed with the Justice Department with respect to the scope of the exemption that should be accorded to the "business of insurance." For example, at the time of the enactment of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, the Justice Department opposed Congress' granting to the "business of insurance" any exemption from the federal antitrust laws, other than a three-year moratorium. *See* Joint Hearings on S. 1362, H.R. 3269 and H.R. 3270 Before the Subcomms. of the Comms. on the Judiciary, 78th Cong., 1st and 2d Sess., pt. 1, at 49-54 (1943); 90 Cong. Rec. A3359-61 (1944); S. Rep. No. 1112, 78th Cong., 2d Sess. 5-6 (1944); H.R. Rep. No. 873, 78th Cong., 1st Sess. 6-8 (1943). *See also* S. Rep. No. 20, 79th Cong., 1st Sess. 1 (1945); H.R. Rep. No. 143, 79th Cong., 1st Sess. 2 (1945); *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 609 n.4 (1976) (Blackmun, J., concurring).

Nor has Congress acted on subsequent efforts of the Justice Department to obtain repeal or modification of the McCarran-Ferguson Act. *See* Dep't of Justice, *The Pricing and Marketing of Insurance: A Report of the United States Department of Justice to the Task Group on Antitrust Immunities* viii-xiii (Jan. 1977); Dennis, *The Justice Department Study—An Update*, 13 Forum 920 (1978); Shenefield, *Insurance—The New Frontier of Deregulation*, 16 Forum 679 (1981).

2 *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

3 650 F.2d at 394, Appendix A to Petition in No. 81-389 at 18a.

review arrangement challenged by respondent's complaint. They also, through strained construction of *Royal Drug* and legislative history, seek to establish much more restrictive criteria for determining whether particular activity is part of the "business of insurance" than required by previous decisions of this Court. Indeed, the interpretation that they urge would largely contravene the ordinary understanding of the "business of insurance" language adopted by Congress in establishing the exemption.

A. The Alleged Peer Review Arrangement Has an Entirely Different Function Than the Pharmacy Agreements in *Royal Drug*

In spite of the procrustean efforts of respondent and amici to fit the challenged peer review activities into the mold of the *Royal Drug* pharmacy agreements, the analogy plainly does not fit. The pharmacy agreements fixed in advance the prices to be charged by participating pharmacies for drugs sold to the insurer's policyholders. These agreements, viewed as nothing more than contracts for the purchase of goods sold by providers, were held to be indistinguishable from countless other business arrangements by which insurance companies purchase goods and services. The insurer's contract with the providers was said to be of a "wholly separate nature" than the contractual relationship between the insurer and insured. (440 U.S. at 216 n.14).

Unlike the pharmacy agreements in *Royal Drug*, the peer review arrangement at issue involves no purchase of goods or services from the chiropractors who sit on the peer review committee nor does it involve any agreement with those chiropractors fixing the fees which they or any other chiropractors charge policyholders. The only activity for which the exemption is sought here is the furnishing of advice by the members of the peer review committee, at the insurer's request, as part of the insurer's process of determining whether and to what extent certain claims of its insureds are within the coverage limitations specified in the policy. This advice only affects the

amount of reimbursement that the policyholder will receive under the policy.

None of the challenged peer review activities involve a determination of the amount that the provider may charge the insured. Chiropractors such as respondent remain free to deal with their patients on whatever terms they wish and to charge whatever fee they feel their services are worth. To the extent that insurance is denied as a result of the peer review process, the chiropractor's fee or service is merely left to the forces of competition. That is, the subsidy of insurance is curtailed through enforcement of the policy limitations, and the consumer may then make a choice based on cost and value, as in any other competitive market.

The sole basis for respondent's complaint is that the insurer, Union Labor Life Insurance Company ("ULL"),[4] acting on the advice of the peer review committee, denied full payment to insureds for fees charged to them by respondent. This is nothing more than a complaint about the manner in which the insurer interpreted its policy and settled its claims. Respondent and amici urge that peer review, like the provider arrangements in *Royal Drug*, is indistinguishable from countless other arrangements by which insurers reduce costs and fulfill their contractual obligations. But that is plainly not the case; unlike such "countless other arrangements" the peer review activities challenged here are an integral part of policy interpretation and enforcement—an activity which this Court has considered the "core" of the "business of insurance."

B. The Participation of Chiropractors in the Peer Review Process Does Not Automatically Vitiate the Exemption

Respondent suggests that an insurer loses the McCarran-Ferguson Act federal antitrust exemption whenever it "looks to . . . parties *outside* the insurance industry." (Resp. Br. 13). Similarly, the Justice Department proposes that a criteria

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4 ULL has no parent company and no subsidiaries other than one which is wholly-owned.

adopted by this Court for determining the scope of the exemption is whether the particular activity "is limited to entities within the insurance industry." (Justice Dep't Br. 11). This Court has adopted no such mechanistic rule, and should not do so, because the results would be contrary to both the language and intent of the Act.

It is true that this Court in *Royal Drug* indicated that the tests for determining what constitutes the "business of insurance" are more easily satisfied by an intra-industry agreement than by an arrangement with persons outside the insurance industry. (440 U.S. at 231). However, the Court adopted no blanket rule excluding any activity that involves or affects persons not normally considered to be within the industry. As the District of Columbia Circuit recently has observed:

> If the Court had intended to establish a simple test of the "business of insurance," which would (1) exclude *any* agreement pertaining to the provision of goods and services other than insurance or (2) ban *any* practice having an impact on a non-insurance market, it could have stated the test simply. It did not. Indeed, the Court's decision in *Royal Drug* was specifically tailored to the vertical agreements it considered in that case.[5]

In fact, this Court reiterated and emphasized in *Royal Drug* that the McCarran-Ferguson Act exemption was not written in

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5 *Proctor v. State Farm Mut. Auto. Ins. Co.*, 1982-1 Trade Cas. (CCH) ¶ 64,606, at 73,302 n.29 (D.C. Cir. 1982). Although the court in *Proctor* held that the vertical agreements between automobile insurers and preferred automobile repair shops were not the "business of insurance," these vertical agreements are quite different from the peer review arrangement at issue. Like the pharmacy agreements in *Royal Drug*, the vertical agreements in *Proctor* provided for the purchase outside the insurance industry of goods and services to be supplied to the insureds, solely for the purpose of reducing the insurer's costs. *Id.* at 73,313. Unlike the peer review arrangement at issue, the automobile repair shops did not aid the automobile insurers in determining the extent of the insurer's obligation under the policy but instead sought to fix the price charged by repair shops for repair services provided to policyholders.

terms of "insurance companies" but extends instead to the "business of insurance."[6] That is, the exemption turns not on the particular persons involved but on the specific activity under consideration. Thus, any activity, such as the peer review in this case, that properly is part of the "business of insurance" comes within the exemption and is not automatically vitiated simply because the insurer looked for advice to professionals who are not considered part of the industry.

The Justice Department's reliance on cases under the Capper-Volstead Act is entirely misplaced. (Justice Dep't Br. 20 n.20). That Act extends the exemption only to specific *persons, i.e.*, "farmers, planters, ranchmen, dairymen, nut or fruit growers" engaged in the production of agricultural products.[7] Since the "enumeration [of exempt persons] is limited in quite specific terms," this Court held that the exemption could not be extended to persons outside the statutory listing.[8] However, McCarran-Ferguson is not such an exemption; Congress chose to extend the immunity not just to specific persons but to the general "business of insurance" for the purpose of encouraging continued regulation of that business by the states.[9]

The labor exemption cases cited in the Justice Department's Brief at 20, note 20, similarly do not support the proposition that an explicit exemption is automatically vitiated by participation of persons outside the industry. Those cases simply hold that a union-employer agreement to force other employers out of business causes the union to lose its exemption. The agreement by its very nature involved an activity which went far

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6 440 U.S. at 217.

7 7 U.S.C. § 291.

8 *Case-Swayne Co. v. Sunkist Growers, Inc.*, 389 U.S. 384, 393 (1967).

9 S. Rep. No. 20, 79th Cong., 1st Sess. 2 (1945); S. Rep. No. 1112, 78th Cong., 2d Sess. 1 (1944); H.R. Rep. No. 143, 79th Cong., 1st Sess. 2 (1945); H.R. Rep. No. 873, 78th Cong., 1st Sess. 1 (1944); 90 Cong. Rec. 6524-26 (1944) (remarks of Rep. Walter).

beyond the purpose of the exemption: the encouragement of collective bargaining. However, no such activity is involved in the peer review activities under consideration here.

The present case does not seek any exemption for activities of the peer review committee other than responding to the insurer's requests for professional advice. As noted, respondent's only complaint, insofar as peer review is alleged to affect him, concerns the use by the insurer of the advice furnished by the peer review committee in applying the insurance policy limitations to certain claims submitted by respondent's patients.

To the extent that peer review members go beyond the role of advising the insurer, to form "cartels" or make "price suggestions" to the chiropractic profession (Justice Dep't Br. 8 n.8) or disseminate fee schedules to the chiropractic profession, the exemption sought here would provide no immunity. Notably, no evidence of such activities has been offered by respondent in this case.

Respondent and amici also suggest that peer review could have an effect of maximum price fixing. But that effect could only result from the insurer's decision to act on advice of the peer review committee so as to limit payments under the insurance contract. Every decision of an insurer concerning the scope and cost of coverage has effects "outside the industry" on the insured and those who provide insureds with covered services. Hence, if the effects of an insurer's activities on persons "outside the industry" were adopted as a controlling criterion, as respondent and amici propose, the exemption would be rendered virtually meaningless.[10]

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10 The attempted "critical distinction" in the Justice Department's Brief at 19, note 17, between the challenged peer review arrangement and an insurer-adjuster agreement is specious. Third-party providers can be affected by an insurer's agreement with a licensed adjuster to the same extent as by an insurer-provider agreement. Indeed, the adjuster, through a desire to maintain a continuing business relationship with the insurer, may be more likely to attempt to restrain prices

C. The Absence of Specific Reference to Peer Review in the Insurance Contract Is Irrelevant

The Justice Department goes so far as to suggest that the exemption should be unavailable because peer review is not specifically mentioned in ULL's contracts with its policyholders. (Justice Dep't Br. 3 n.2, 6, 14-15, 28). Such a requirement would be absurd.

Obviously, ULL's insurance policies cannot spell out all the activities that are required for proper underwriting, execution, interpretation and enforcement of the policy. There is no more reason for the policy to specify peer review as part of the claims adjustment function than to list actuarial arrangements as part of the rating function. Indeed, this Court clearly indicated in *Royal Drug* that the essential test is whether the challenged activity is of a "wholly separate nature" from the insurer-insured relationship and not whether the activity is "referred to in the insurance policies."[11] Peer review directly involves the "interpretation" and "enforcement" of ULL's contracts with its insureds. It is part of the insurer's process of determining whether and to what extent certain claims are covered by the limitations specified by the policy. Therefore, unlike the pharmacy agreements in *Royal Drug*, peer review cannot be said to be of a "wholly separate nature" from the insurer-insured relationship. This fact is in no way altered by the policy's lack of specific reference to peer review.

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charged by provider's to policyholders. However, as the Justice Department Brief at 9, note 8, concedes, nothing in the antitrust laws requires an insurer to refrain from seeking expert advice that will assist it in controlling costs. The only question is whether the insurer is meeting its obligations to its policyholders, and that is a matter which the Superintendent of Insurance is required to supervise under the provisions of the New York Insurance Law.

11 The Court refused to accept an argument by the petitioners in *Royal Drug* that the absence of the pharmacy agreements would constitute a breach of the insurance contract terms, holding that (440 U.S. at 216 n.14):

> The wholly separate nature of the two categories of agreements is in no way affected by the fact that the Pharmacy Agreements are indirectly referred to in the insurance policies.

II.

NEW YORK STATE REGULATES THE CHALLENGED ACTIVITY AND THE HOLDING SOUGHT BY RESPONDENT WOULD INTERFERE WITH THAT REGULATION

It is unnecessary for petitioners to show, as the Justice Department Brief at 25 suggests, that application of the Sherman Act would "invalidate, impair or supersede" any law enacted by New York State. Both the wording of section 2(b) of the McCarran-Ferguson Act and the statutory history[12] make clear that to the extent that a state has acted to regulate the business of insurance, the federal antitrust laws ipso facto are displaced.

The contention of respondent and amici that the state regulation must expressly name the particular practice is equally without merit. (Resp. Br. 5, 25; Justice Dep't Br. 27, 28). State legislation and administrative regulations patently cannot be expected to itemize each and every activity that various insurers may use in the underwriting, execution, interpretation and enforcement of policies. Such detailed specification, even if feasible, would destroy the flexibility and discretion which are essential to effective administrative supervision.[13] So long as the general scheme of regulation allows administrative supervision of the particular practice, there is no need for specific reference in the statute or regulations. As

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12 Senator Ferguson stated that "if a State passes an act regulating insurance or taxing insurance, and that act is contrary to the Sherman Act or the Clayton Act, with three exceptions [boycott, intimidation or coercion], then the State law would be the law." 91 Cong. Rec. 1481 (1945). *See also id.* at 1478 (remarks of Sens. McCarran and Pepper); *id.* at 1480-81 (remarks of Sens. Ferguson and Murdock); *id.* at 1482-84 (remarks of Sen. Pepper); *id.* at 1484 (remarks of Sen. Murdock).

13 *See Far East Conference v. United States*. 342 U.S. 570, 575 (1952); 1 *Am. Jur.* 2d, Administrative Law § 12, at 815 (1962).

discussed in ULL's Brief at 31-34, New York's prevasive scheme of regulation and supervision of insurance amply provides for regulation of ULL's policy interpretation and enforcement practices, including peer review.

This Court in *FTC v. National Casualty Co.*, 357 U.S. 560 (1958), held that the section 2(b) proviso is satisfied by a state's general legislative prohibition designed to guarantee certain standards of conduct and providing for enforcement through a scheme of administrative supervision. The Court explicitly rejected an argument, similar to that made here, that the general scheme, to be effective, has to be "crystallized into 'administrative elaboration of these standards and application in individual cases.' " (*Id.* at 564).

Also without merit is the related argument of respondent and amici that the particular practice must be specifically authorized or required by state law. ULL is licensed by New York State to engage in the health insurance business. (ULL Br. 3). This necessarily includes authorization to conduct all activities incidental to the conduct of such business,[14] including steps, such as peer review, necessary to achieve the proper adjustment of losses. Indeed, ULL is required by New York State law to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies. (ULL Br. 32). Furthermore, respondent and amici ignore this Court's holding in *FTC v. National Casualty Co., supra,* which teaches that legislative *prohibition* designed to guarantee certain standards of conduct—such as New York's prohibition of unfair claim settlement practices—is sufficient to satisfy section 2(b) of the McCarran-Ferguson Act.

The brief of amici States of Arizona, *et al.*, at 17 *et seq.*, extensively argues that the standards of *Parker v. Brown,* 317 U.S. 341 (1943), must be followed in measuring the scope of the section 2(b) exemption. However, such a proposal was

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14 N.Y. Ins. Law § 46 (McKinney Supp. 1981) permits a licensed insurer to engage in activities "necessarily and properly incidental to the kinds of business which it is authorized to do in this state."

rejected by Congress. As noted in *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 609 n.4 (1976) (Blackmun, J., concurring):

> The Justice Department, in opposing the McCarran-Ferguson Act, specifically argued that *Parker v. Brown*, 317 U.S. 341 (1943), made the legislation unnecessary because it immunized the insurance business insofar as it was regulated by the States. Congress was not so sure:
>
> "*Parker v. Brown* dealt with a State commission authorized by State statute to enforce a program in conformity with, if not supplementary to, a Federal statute. Obviously, all State regulation concerning insurance does not and would not fall in such a category." S. Rep. No. 1112, 78th Cong., 2d Sess., 2, 5-7 (1944). See also S. Rep. No. 20, 79th Cong., 1st Sess., 1, 1-3 (1945); H.R. Rep. No. 873, 78th Cong., 1st Sess., 7 (1943); H.R. Rep. No. 143, 79th Cong., 1st Sess., 4 (1945).

Finally, even if the Justice Department standard were correct and the federal antitrust laws could apply to the business of insurance to the extent that "it would not interfere with state regulation or expose the insurer to conflicting requirements under state and federal law" (Justice Dep't Br. 25), such interference and conflict would be created here. The holding sought by the Department and respondent in this Court would directly interfere with state regulation and expose ULL to conflicting requirements.

A. Interference With Claims Adjustment Regulation Under the New York Insurance Law

Respondent's complaint alleges that, as a result of peer review, purchasers of chiropractic services from him "have been deprived of the insurance coverage to which they are entitled by [ULL] under the terms of its insurance policies." (J.A. 8a). Assuming, *arguendo*, the truth of this allegation, then ULL has violated section 40-d of the New York Insurance Law (McKinney Supp. 1981), which specifically prohibits unfair claims settlement practices, including "not attempting in

good faith to effectuate prompt, fair and equitable settlements of claims . . . . " Pursuant to article IX-D of the Insurance Law (McKinney 1966 & Supp. 1981), and regulations thereunder adopted by the Superintendent,[15] persons deprived of insurance coverage to which they are entitled can complain to the Insurance Department.

Respondent makes no claim that he or any of his patients have ever made a complaint to the Insurance Department concerning ULL's failure to provide an insurance subsidy to the full extent of any fee charged by respondent.[16] Instead, he seeks a judgment under the Sherman Act proscribing ULL's claim settlement practices involving peer review. Thus, respondent would prohibit outright, through the federal antitrust laws, claim settlement practices which the Superintendent might conclude are fair or reasonable as particular circumstances indicate. Such a result would interfere with the state's regulatory authority by introducing a different standard, to be administered by federal courts, than the standard administered by the Superintendent under the New York Insurance Law.

Indeed, the construction of the McCarran-Ferguson Act urged by respondent and the Justice Department likely would interfere with all state law governing insurance claims adjustment. This is so because, like the Second Circuit, they suggest that any insurance company activity occurring after the issuance of the policy is not part of the business of insurance. Since all claims adjustment may be said to occur at such point, the result would be wholesale interference with state laws regulating insurance claims adjustment.

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15 State of New York, *Official Compilation of Codes, Rules and Regulations* tit. 11, pt. 216.

16 Apparently, respondent's insured patients failed to follow his recommendation that they complain to the Insurance Department regarding ULL's use of peer review. (Resp. Br. 28). Nor did respondent pursue his remedies by taking an assignment of any insured's claim against the insurer and then filing a complaint with the Insurance Department.

B. Interference With Policy Regulation Under the New York Insurance Law

Contrary to the Justice Department's construction of the complaint in this case,[17] respondent has expressly attacked the insurance policy terms approved by the New York Superintendent of Insurance.[18] Specifically, his demand for relief seeks, *inter alia,* a judgment by the federal court that the insurance company "be required to cancel those provisions of its insurance policies and every other rule or statement of policy which has the purpose or effect of suppressing or restricting free and open competition in the sale of chiropractic services." (J.A. 9a). It is clear that the requested judgment would be in direct conflict with the Superintendent of Insurance's approval of the same policy provisions. Thus, application of the federal antitrust laws here undoubtedly would interfere with the state's regulation.

C. The New York State Antitrust Law

The Justice Department contends that "state antitrust laws are not legislation enacted 'for the purpose of regulating the business of insurance.' " (Justice Dep't Br. 31). This plainly ignores the purpose of the New York legislature when in 1948 it amended the state antitrust law to make it applicable to "licensed insurers . . . and other persons and organizations subject to the provisions of the insurance law." (N.Y. Gen.

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17 The Justice Department acknowledges that: "Regulation of policy terms furthers the state's interest in supervising the contractual obligations and rights of insurers and policyholders." (Justice Dep't Br. 28-29). Apparently attempting to avoid the consequences of this acknowledgment in relation to the facts of this case, the Department then chooses simply to ignore a major part of respondent's complaint, stating as follows: "We do not understand the complaint to challenge ULL's policy terms or the insurer's decision not to pay certain claims . . . . " (Justice Dep't Br. 26 n.35).

18 J.A. 17a. The Superintendent's approval was made pursuant to the requirements of N.Y. Ins. Law § 154 (McKinney 1966 & Supp. 1981) which was enacted to protect policyholders in the state.

Bus. Law § 340[2] [McKinney 1968]). The express intent of the state legislature was to "accept Congress' invitation to regulate the insurance business." (N.Y. Legis. Doc. No. 46, at 36 [1948]).

The semantic distinction between statutory "regulation" and "prohibition" (Justice Dep't Br. 29-31) has no basis in logic or history. Obviously, a state antitrust statute which prohibits certain anticompetitive conduct within the business of insurance, and further provides for ongoing enforcement by the state attorney general,[19] is at least as effective in controlling activities within that business as a law that provides only for administrative supervision.

Congressional recognition that state antitrust laws would constitute "regulation" within the meaning of section 2(b) of the McCarran-Ferguson Act is evidenced by the following remarks of Senator Pepper, which are omitted from the Justice Department's quotation from the final Senate debate:

> [T]he legal effect of the proviso which the Senator has just read is that a State can absolutely prevent the applicability of the Sherman Antitrust Act and the Clayton Act to insurance companies doing business in the State by passing a State act which will make combinations and restraints of trade unlawful in that State.

(91 Cong. Rec. 1444 [1945]). New York followed this prescription (*supra*).

Furthermore, this Court has made clear that state "prohibitory legislation" satisfies the section 2(b) proviso. (*FTC v. National Casualty Co.*, 357 U.S. 560, 564 [1958]).

Accordingly, the District Court below properly held that under the provisions of the Donnelly Act,[20] as it applies to the

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19 N.Y. Gen. Bus. Law §§ 340, 342-43, 347 (McKinney 1968 & Supp. 1981).

20 N.Y. Gen. Bus. Law §§ 340-47 (McKinney 1968 & Supp. 1981).

business of insurance, New York has sought to regulate the very conspiratorial conduct alleged in respondent's complaint, so that on this basis alone, the McCarran-Ferguson Act exemption should operate as a bar to plaintiff's federal antitrust claims.

CONCLUSION

For the foregoing reasons, it is respectfully requested that the judgment of the Second Circuit be reversed and the judgment of the District Court dismissing the complaint be directed to be reinstated.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY and
NEW YORK STATE CHIROPRACTIC ASSOCIATION,
Petitioners,

v.

A. ALEXANDER PIRENO,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF *AMICI CURIAE* OF THE AMERICAN INSURANCE ASSOCIATION, THE ALLIANCE OF AMERICAN INSURERS AND THE NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

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Brief for the United States as Amicus Curiae, *Group Life & Health Insurance Co. v. Royal Drug Co.*, No. 77-952 (U.S. 1979) 12, 22

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

No. 81-389, 81-390

UNION LABOR LIFE INSURANCE COMPANY and
NEW YORK STATE CHIROPRACTIC ASSOCIATION,
Petitioners,

v.

A. ALEXANDER PIRENO,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF *AMICI CURIAE* OF THE AMERICAN INSURANCE ASSOCIATION, THE ALLIANCE OF AMERICAN INSURERS AND THE NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

INTEREST OF *AMICI CURIAE*

Pursuant to Rule 36 of the Rules of this Court and with the consent of all parties,[1] the American Insurance Association ("AIA"), The Alliance of American Insurers ("The Alliance") and the National Association of Independent Insurers ("NAII") respectfully file this brief *amici curiae* in support of petitioners, the Union Labor Life Insurance Company and the New York State Chiropractic Association.

AIA is a voluntary trade association of approximately 150 insurance companies; The Alliance is a voluntary

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[1] Letters of consent have been filed with the Clerk.

trade association of approximately 150 insurance companies; and NAII is a voluntary trade association of over 500 insurance companies. Together, these companies account for nearly 70 percent of the property and casualty insurance written in the United States.[2]

The Court of Appeals in this case concluded that a health insurer's requests for information and advice from a medical peer review committee for purposes of determining claims payments to insureds are not part of the "business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b) ("McCarran Act"). In consequence, it ruled that such activity does not qualify for the antitrust exemption afforded by the statute as part of Congress' policy of deferring to state insurance regulation.

The decision has major consequences for the property and casualty insurance industry. Like the health insurance policies in this case, which promise reimbursement for "usual," "customary" and "reasonable" medical fees, property and casualty insurance policies contain provisions promising cash benefits in indeterminate amounts. For example, homeowner policies typically promise to pay the "replacement value" of a dwelling, and automobile policies the "reasonable cost" of repair. Thus, when a loss is suffered, property and casualty insurers must, like health insurers, interpret and implement these provisions in determining the extent to which the insured is entitled to reimbursement under his policy. Interpretation of these provisions, in turn, requires col-

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[2] Property and casualty insurance protects individuals and commercial enterprises against loss or damage to the insured's property caused by fire, theft, collision and other perils and against losses arising from the insured's legal liability for injuries to other persons or damage to the property of others. The major lines of property and casualty insurance include automobile liability and physical damage, homeowners' multiple peril, commercial fire, workers' compensation, products liability and medical malpractice liability.

lecting information from third parties, such as automobile repair shops and home construction companies, on the costs of the goods and services required to repair or replace the property of the insured or of persons asserting a claim against the insured. Indeed, with regard to policies providing personal injury liability coverages, property and casualty insurers have occasion to collect medical cost information similar to that at issue in this case. For the first time, and notwithstanding extensive state regulation, the decision of the Court of Appeals brings this critical element of the claims adjustment and settlement process within the purview of the antitrust laws.

The decision below has even broader ramifications for property and casualty insurers. The peer review committee established by the New York State Chiropractic Association to provide claims-related information to health insurers performs a function similar to that performed by claims adjusters utilized by property and casualty insurers. The decision of the Court of Appeals suggests that this entire process—the adjusting and settling of insurance claims—is not a part of the insurer-policyholder relationship which this Court has considered to be central to the "business of insurance."

This unprecedented view of the insurance business creates the potential for the federal antitrust laws to supersede or impair state regulation of claims adjustment practices, contrary to the purpose of the McCarran Act. In adjusting and settling claims, member companies of the *amici* associations will face the dilemma of complying with federal antitrust standards while at the same time following potentially conflicting state standards on matters integrally related to claims settlement such as rate-making, underwriting and policy approval. In addition, the decision below will frustrate efforts of property and casualty insurers and state regulatory officials to reduce the spiraling cost of insurance and to fairly and efficiently

provide insureds with the benefits to which they are entitled under their policies.

SUMMARY OF ARGUMENT

I.

The court below held that a health insurer's request for information and advice from a medical peer review group, solely for the insurer's use in determining its obligation to reimburse policyholders for losses, was not within the exemption to the antitrust laws accorded to the "business of insurance" by the McCarran Act. The Court of Appeals' decision principally was shaped by its belief that the "business of insurance" involves only the assumption and transfer of risk and that the process of determining claims payments has no role in risk transfer. This view of the "business of insurance" ignores an essential reality of that business consistently recognized by this Court—that the insurer-insured relationship does not end with the mere issuance of a policy but is a continuous process culminating in the payment of claims whenever the policyholder suffers a loss.

In most insurance policies, the insurer's assumption of risk is not defined as a fixed cash amount, but rather by such terms as the "reasonable cost of repair," the "replacement cost," or the "usual, customary and reasonable" cost of medical treatment. When the insurer receives a notice of loss from the policyholder, it must interpret and implement these terms before reimbursing the insured for the amount to which he is entitled. Because the insurer frequently does not have in its possession the necessary cost information relating to the benefits promised in the policy, it must have recourse to third party sources of information. For example, in policies covering the insured against collision damage to his automobile, the insurer will often survey automobile repair shops to determine the "reasonable cost of repair."

Without access to such information, the insurer could not interpret the terms of the policy and the policyholder

might not receive the benefits which the policy promises. The central flaw in the decision below is its failure to recognize that this information-collecting process is necessitated by the policy and arises directly out of the insurer's obligations to its policyholders. It thus forms an essential part of the insurer-policyholder relationship which this Court uniformly has held to lie at the heart of the "business of insurance."

The Court of Appeals' refusal to acknowledge that claims adjusting is an integral part of the insurance process appears to have resulted from two fundamental misreadings of this Court's decision in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). First, the Court of Appeals believed that *Royal Drug* overturned the prior holding in *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969) that the interpretation and enforcement of the insurance contract are just as much a part of the "business of insurance" as the assumption and transfer of risk. In fact, however, *Royal Drug* expressly reaffirmed that holding. Neither explicitly nor impliedly did the Court hold that the "business of insurance" is limited to the assumption of risk, to the exclusion of a wide variety of other activities such as the selling and advertising of policies and ratemaking —activities which have always been considered part of the insurance business although not in themselves involving the spreading of risk.

Even accepting the lower court's premise—that the "business of insurance" is confined to the spreading of risk—its decision was erroneous. Most insurance policies, at the time issued, do not fully transfer risk from the policyholder to the insurer. This is because the benefit is expressed in unquantified terms. The underwriting of the policy thus begins a process which does not end until the insurer interprets these policy provisions and completes the transfer of risk by determining the amount of the cash payment due the policyholder. In short, claims adjustment is the process by which the insurer finally

determines how much risk it has assumed and how much is retained by the policyholder.

Second, the lower court erred in construing *Royal Drug* as denying McCarran Act immunity for any insurance company arrangements with third parties that have the effect of reducing the insurer's costs and thus enhancing its reliability. In fact, *Royal Drug* looked, not to the presence of a cost reduction effect, but to the relationship between the third party arrangement and the insurance contract. Because the policy language in *Royal Drug* defined the benefit in fixed terms—prescription drugs in return for payment of a premium—the Court held that arrangements between the insurer and pharmacies on the cost of such drugs had no bearing upon the insurer's obligations to the policyholder. Thus, the insurer-pharmacy contracts operated *only* to reduce the insurer's costs and could not be distinguished from a variety of other business practices also having no real impact upon the policyholder. But where, as in this case, the policy language does not fix the transfer of risk at the time of issuance, but needs further interpretation, the insurer's construction of that language is directly connected to and arises out of the insurance contract. Any cost reduction resulting from the insurer's collection of claims-related information is incidental to its obligation of implementing the policy.

There is another important distinction between the practices considered in *Royal Drug* and those in this case. Unlike the pharmacy contracts in *Royal Drug*, which determined the price of goods and services in a noninsurance market, an insurer's collection of information solely to determine claims payments does not risk extension of the McCarran Act to immunize anticompetitive activity in a separate market. Notwithstanding the amount of the claims payment to the policyholder, all providers of goods and services to the insured remain free to charge whatever prices they desire. No purchase of goods and services by the insurer is involved. More-

over, it is only the third party's act of providing information to the insurer for its use in determining claims payments that constitutes part of the "business of insurance." Any attempt by third parties to misuse this information in the pricing of noninsurance goods and services would be fully subject to the Sherman Act.

II.

The legislative history of the McCarran Act supports the conclusion that an insurer's collection of claims-related information, as well as the entire process of claims adjustment and settlement, was intended by Congress to be part of the "business of insurance." The McCarran Act was based upon an earlier bill proposed by the National Association of Insurance Commissioners, which specifically included claims adjustment practices within its scope. Moreover, the congressional debates disclose that claims practices were among the types of activities that Congress intended to be covered. Finally, because the McCarran Act was designed to protect and foster state insurance regulation, the existence of numerous state laws governing claims adjustment and settlement both *prior to* and *following* passage of the McCarran Act provides further confirmation that these activities are part of the "business of insurance."

III.

If allowed to stand, the decision below would permit the federal antitrust laws to frustrate state insurance regulation, contrary to the underlying purpose of the McCarran Act. Congressional deference to state insurance regulation would exist only with regard to the "front end" of the relationship between the insurer and the insured—underwriting, ratemaking and sales practices. State regulation would no longer be supreme at later stages in the insurance process, notwithstanding that the payment of claims is integrally related to the setting of rates and the insurer's ability to underwrite

risk. The decision below thus would return an important segment of the "business of insurance" to the situation which Congress thought it had remedied in 1945.

ARGUMENT

I. CLAIMS ADJUSTMENT, INCLUDING THE COLLECTION OF CLAIMS INFORMATION, IS AN INTEGRAL PART OF THE "BUSINESS OF INSURANCE"

The holding of the court below is that an insurer's collection from a third party of information and advice needed to determine claims payments owed to policyholders is not a part of the "business of insurance." Indeed, the Court of Appeals went so far as to suggest that the entire process of adjusting claims is not conduct subject to the McCarran Act's scheme of federal deference to state insurance regulation. *Pireno v. New York State Chiropractic Association*, 650 F.2d 387, 393-95 (2d Cir. 1981). App. 14a-18a.[3] Both of these novel propositions are based upon fundamental misunderstandings of the insurance business and misreadings of this Court's prior decisions.

This Court has held that the "business of insurance" is to be defined in terms of its "ordinary understanding . . . illuminated by any light to be found in the structure of the Act and its legislative history." *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979). In doing so, the Court has focused the inquiry on whether the conduct in question is integral to the relationship between insurer and insured. Thus, in *Group Life & Health Insurance Co. v. Royal Drug Co.*, *supra*, at 211, 215, the Court held that the "business of insurance" consists not only of "the spreading and underwriting of a policyholder's risk," but also to other matters relating "to the contract between the insurer and the in-

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[3] Appendix to Petition for Writ of Certiorari of Union Labor Life Insurance Company.

sured." Similarly, in *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), the Court identified "the core of the 'business of insurance' " as encompassing "the type of policy which could be issued, its reliability, interpretation, and enforcement . . . ." *Id.* at 460. Whether viewed as part of the risk-spreading process or as interpretation or enforcement of the insurance contract, claims adjustment and settlement lie well within the boundaries of the "business of insurance" previously established by this Court.

A. Claims Adjustment Is Of Primary Concern To The Policyholder

Claims adjustment is the " 'payoff' end of the [insurance] business." [4] It determines how much the insurer will pay to the insured when he suffers a loss.[5] Thus, claims adjustment is at the heart of the relationship between the insurer and the insured.[6] It is the point at

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[4] Walton, *Company Organization and Management*, in PROPERTY & LIABILITY INSURANCE HANDBOOK 893, 902 (J. Long & D. Gregg eds. 1965). Claims adjustment has been characterized as one of the functions "essential to the very existence and basic purposes of a property-liability insurance corporation . . . ." *Id.* at 896.

[5] *See generally* D. BICKELHAUPT & J. MAGEE, GENERAL INSURANCE 111 (8th ed. 1970); R. RIEGEL & J. MILLER, INSURANCE PRINCIPLES AND PRACTICES 550, 552-54 (5th ed. 1966); C. BRAINARD, AUTOMOBILE INSURANCE 512 (1961).

[6] Perhaps nothing more clearly demonstrates that claims adjustment relates to "the contract between the insurer and the insured," Group Life & Health Ins. Co. v. Royal Drug Co., *supra*, 440 U.S. at 215, than the fact that "[a] large part of the policy describes procedures for loss adjustment." R. MEHR & E. CAMMACK, PRINCIPLES OF INSURANCE 249 (6th ed. 1976). For example, the claims adjustment process is initiated when the insured performs his contractual duty of filing a notice of loss with the insurer. *See* D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 111; C. BRAINARD, *supra* note 5, at 513. The standard property insurance policy also requires the insured to file a "proof of loss" regarding the value of his destroyed or damaged property. *See* R. MEHR & E. CAMMACK, *supra*, at 256-58; Butler, *Loss Adjustment In Fire Insurance*, in

which the insurance company "deliver[s] the goods which the agent has sold." [7] It occurs when the insured "suddenly has insurance uppermost in his mind, and not as a tangible but possibly never-to-be-used contract . . . :" [8]

> The adjustment (including payment) of claims represents the final act in the insurance process. The payment of a claim by an insurance company brings the insurance contract "to life" in a fashion far more vivid than does any other single act in connection with the purchase, issuance, and maintenance of the contract.[9]

In the eyes of the insured, the manner in which this function is performed is of fundamental importance and is the critical determinant of the reliability of the policy; it determines whether the insured will receive the protection against the risk of loss which was sought in purchasing the insurance.[10]

B. Claims Adjustment Transfers And Spreads Risk Under The Insurance Policy

The insurance policy is a contract through which an individual seeks to obtain indemnification for losses

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PROPERTY AND LIABILITY INSURANCE HANDBOOK, *supra* note 4, 219, 227. As a practical matter, the claims adjuster assists the insured in completing this "proof of loss" after the value of the loss has been established as a result of the claims adjustment process. *See* R. MEHR & E. CAMMACK, *supra*, at 560; Butler, *supra*, at 227.

[7] D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 110.

[8] W. MOORE, A PRIMER ON ADJUSTMENTS 8 (2d ed. 1955).

[9] Butler, *supra* note 6, at 219. *See also* D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 110.

[10] *See* C. CISSLEY, CLAIM ADMINISTRATION: PRINCIPLES & PRACTICES 9 (1980); D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 110-11; Walton, *supra* note 4, at 902. One treatise characterizes the prompt and fair payment of losses as the "*raison d'etre* of [the insured's] premium payment." S. HUEBNER, K. BLACK & R. CLINE, PROPERTY AND LIABILITY INSURANCE 631 (2d ed. 1976) (hereinafter "S. HUEBNER").

caused by the occurrence of risk.[11] However, no insurance policy is a transfer of all forms of risk to which the insured may be exposed or even a transfer of all of the specific risks to which the policy relates.[12] The insurer assumes only those risks occasioned by the perils specified in the contract.[13] Similarly, the policy contains specific limitations on the amount of risk assumed—expressed as a flat dollar ceiling (the "policy limit") and with further limitations within the policy limit, such as the "reasonable repair cost" of an automobile.[14] Thus, as a practical matter, transfer of risk is not fully effectuated at the time the policy is executed. Rather, the policy by its terms provides that the insurer will assume and spread the risk only upon its occurrence, and then subject to the limitations and definitions set forth in the policy.[15]

Claims adjustment and settlement is the process by which risk is actually transferred under the insurance policy. It is the definitive determination of what portion of the risk will be borne by the insured and what portion will be borne by the insurer. The Solicitor General recognized this in his brief in *Royal Drug*: "The formula for the payment of insurance claims [contained in intra-

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[11] *See, e.g.*, German Alliance Ins. Co. v. Lewis, 233 U.S. 389, 411 (1914); R. MEHR & E. CAMMACK, *supra* note 6, at 5, 165; 1 G. COUCH ON INSURANCE 2d § 1.2 at 28 (2d ed. 1959) (hereinafter "G. COUCH").

[12] *Cf.* R. RIEGEL & J. MILLER, *supra* note 5, at 29; C. BRAINARD, *supra* note 5, at 512.

[13] *See* 9 G. COUCH, *supra* note 11, § 39.2-3 at 434-35; 15 *id.* § 54.6 at 326. *See also* R. MEHR & E. CAMMACK, *supra* note 6, at 192-94.

[14] *See, e.g.*, 15 G. COUCH, *supra* note 11, § 54.77 at 365, § 54.124-25 at 391-92, § 54.231 at 456; R. MEHR & E. CAMMACK, *supra* note 6, at 222, 223-24, 229-30; S. HUEBNER, *supra* note 10, at 74; R. RIEGEL & J. MILLER, *supra* note 5, at 554.

[15] *See generally* 1 G. COUCH, *supra* note 11, § 1.2 at 28, 31, § 1.49 at 66-67.

industry claims adjustment agreements] is an integral part of any contract of insurance, because it determines how much risk is involved, and how much of the risk will be assumed by the insurer." [16] Thus, contrary to the suggestion of the Court of Appeals, by no means is claims adjustment merely "an aid in determining the scope of the transfer [of risk] after it has been made." 650 F.2d at 393. App. 15a.

Neither are collection of claims information and other claims adjustment activities "simply a form of cost reduction," *id.*, such as that addressed in *Royal Drug*. The result in *Royal Drug* was not based on the fact that the insurer's agreements to purchase prescription drugs from pharmacies reduced the insurer's costs. Rather, the Court reasoned that those agreements were not the business of insurance because they operated *only* to reduce the insurer's costs and did not operate to assume the insured's risk or otherwise play a part in the insurer-insured relationship.[17] This was because the policies issued by Blue Shield, not the provider agreements, promised the policyholders that their premiums would cover the cost of prescription drugs, minus a small deductible, whatever those costs might be. The policyholder simply had no concern with the price at which the insurer could obtain such drugs. Contracts between the insurer and pharmacies to supply the policy benefits, therefore, did not effect the transfer of risk from *insured to insurer*, but only reduced the cost that had to be paid by the *insurer to a third party*. Viewed in this light, the pharmacy agreements were "merely arrangements for the purchase of goods and services . . . ." 440 U.S. at 214.

In contrast to the provider agreements in *Royal Drug*, the collection of claims information and advice from a

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[16] Brief for the United States as Amicus Curiae, Group Life & Health Ins. Co. v. Royal Drug Co., No. 77-952 (U.S. 1979) at 31 (hereinafter "Brief of Solicitor General").

[17] *See* 440 U.S. at 214 & n.12. *See also* Ratino v. Medical Serv., [1981-1] Trade Cas. (CCH) ¶ 64,144 (D. Md. 1981).

peer review group or other third party source aids the insurer in determining the amount which the policyholder will receive and thus the amount of risk transferred.[18] In short, claims adjustment determines *whether* and *to what extent*, not *how*, the insurer's promise to pay is kept. *See* 440 U.S. at 214. The impact of claims adjustment on the insurer's costs should not obscure the fact that this process represents the completion of the transfer of risk begun when the policy was issued.

C. Claims Adjustment Is The Interpretation And Enforcement Of The Insurance Policy

In addition to transferring risk, claims adjustment is the process through which the insurer discharges its obligation to its policyholders. By determining the extent to which the insured obtains reimbursement under the policy, claims adjustment is nothing less than the "interpretation and enforcement" of the insurance contract, previously identified by this Court as lying within the "core of the 'business of insurance.'" *SEC v. National Securities, Inc.*, *supra*, 393 U.S. at 460.

The claims adjustment process occurs through negotiations between the claims adjuster and the insured, utilizing information which must, of necessity, be obtained from third parties.[19] In most homeowner, automobile and other property and casualty policies, the amount of the loss for which the insured can receive reimbursement is defined in terms such as the "replacement value" or "reasonable repair cost." To quantify these policy terms, the insurer must obtain price information from third parties who provide the goods and services on the basis of which the insured's particular loss can be measured.[20]

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[18] *See generally* C. BRAINARD, *supra* note 5, at 512.

[19] *See generally* P. THOMAS & P. REED, ADJUSTMENT OF PROPERTY LOSSES 9-12 (4th ed. 1977).

[20] *See, e.g.*, P. THOMAS & P. REED, *supra* note 19, at 9-11, 182, 188-90; R. MEHR & E. CAMMACK, *supra* note 6, at 223-24; D. BICKEL-

For example, in the case of automobile property damage, the claims adjuster must obtain information on the normal cost of the necessary parts, the customary amount of labor required to complete the required repairs and the range of competitive hourly labor rates[21]—because these factors define the limitations on the insurer's liability under the standard property and casualty policy.

In deciding that this process of collecting claims information is not the "business of insurance," the Court of Appeals incorrectly viewed the insurance business as ending at the point where the policy is issued and risk is ostensibly transferred. More importantly, the Court of Appeals in effect defined the "business of insurance" as

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HAUPT & J. MAGEE, *supra* note 5, at 121; Butler, *supra* note 6, at 226; W. MOORE, *supra* note 8, at 50. *See also* Quality Auto Body v. Allstate Ins. Co., 660 F.2d 1195 (7th Cir. 1981). *Cf.* Chick's Auto Body v. State Farm Mut. Auto. Ins. Co., 168 N.J. Super. 68, 401 A.2d 722, 725 (Super. Ct. Law Div. 1979), *aff'd*, 176 N.J. Super. 320, 423 A.2d 311 (Super. Ct. App. Div. 1980) (insurer's knowledge of prices required to discharge obligations to insured imposed by State law).

Nor are the limitations on the maximum amount of risk which the insurer will assume the only policy terms which are interpreted during claims adjustment. The claims adjuster must also interpret other provisions of the policy, such as those identifying the property, specifying the perils insured against and imposing conditions on the insured which, if not satisfied, could invalidate the claim. *See, e.g.*, R. MEHR & E. CAMMACK, *supra* note 6, at 252-54, 559-60; Butler, *supra* note 6, at 222-23. *See also* W. MOORE, *supra* note 8, at 7-9, 53.

[21] *See, e.g.*, Chick's Auto Body v. State Farm Mut. Auto. Ins. Co., *supra*, 401 A.2d at 725; W. MOORE, *supra* note 8, at 50, 85. The collection of information required to adjust the insured's claim can occur in a variety of different ways. For example, automobile insurers may rely either on periodic surveys of automobile repair shops conducted by the insurer's personnel or on reports from individual adjusters based on their contacts with repair shops. *See, e.g.*, Quality Auto Body v. Allstate Ins. Co., *supra*, 660 F.2d at 1197-98; Workman v. State Farm Mut. Auto. Ins. Co., 520 F. Supp. 610, 613 & n.5 (N.D. Cal. 1981).

consisting *exclusively* of the assumption of risk—to the exclusion of other activities forming part of the insurer-insured relationship. But as *Royal Drug* and other decisions make clear, assumption of risk by the insurer is only one standard for determining if conduct is part of the "business of insurance." If a bona fide insurance policy exists, then the "reliability, interpretation and enforcement" of that policy are also the "business of insurance." *SEC v. National Securities, Inc., supra*, 393 U.S. at 460.

Accordingly, in *Royal Drug*, after determining that the insurer's side agreements with pharmacies did not involve the underwriting of risk, the Court turned to the question of whether those agreements affected the reliability or enforcement of the insurance contract. *See* 440 U.S. at 214-17.[22] The Court held they did not, for reasons which do not apply here. Basically, the Court found that the pharmacy agreements did not entail enforcement of the policy since "the benefit Blue Shield provides its policyholders is the assurance that they can obtain drugs in return for a direct maximum payment of $2 for each prescription." *Id.* at 216 n.14. Since the policy itself defined this benefit in terms of a product, and because the provider agreements governed only the insurer's payments to the pharmacies, the agreements were not necessary to define the extent of the insurer's obligation to provide that "in-kind" benefit to the insured. In contrast, the collection of information to calculate claims payments is essential when the policy promises coverage in the

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[22] In relying on SEC v. Variable Annuity Life Ins. Co. of America, 359 U.S. 65 (1959), the Court of Appeals confused this distinction. There, the Court held that a variable annuity contract, under which the "insured" continued to bear all investment risks, was not a true contract of insurance since the "insurer" assumed no risk at all. Thus, there was no need to determine whether the implementation of that contract was also the "business of insurance."

form of cash payments for the "reasonable repair cost" of an automobile, the "replacement value" of a residence, or the "usual," "customary" and "reasonable" cost of medical services. Without such information, the insurer's indeterminate obligation to policyholders could never be implemented and the policyholder's rights fairly and effectively enforced.

D. Claims Adjustment Determines An Insurer's Status As A Reliable Insurer

Beyond its risk transfer and payout functions, claims adjustment is one of the "activities of insurance companies [that] relate so closely to their status as reliable insurers that [it] too must be placed [within the "business of insurance"]." *SEC v. National Securities, Inc.*, *supra*, 393 U.S. at 460.[23]

From the individual insured's perspective, an insurer's reliability *is* the prompt and adequate payment of claims when a loss is suffered.[24] Moreover, an insurer's claims adjustment policies directly affect its reputation among *all* of its insureds.[25] A record of inadequate or delayed claims payments can adversely affect the volume of an insurer's business and the stability of its operations, and, for the industry as a whole, can undermine public confidence in its reliability.[26]

Claims adjusting is also intimately related to an insurer's performance of its other major functions, rate-

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[23] *See* Proctor v. State Farm Mut. Auto. Ins. Co., 182 U.S. App. D.C. 264, 561 F.2d 262, 265 n.5 (1977), *vacated and remanded*, 440 U.S. 942 (1979).

[24] *See, e.g.*, S. HUEBNER, *supra* note 10, at 631; P. MAGARICK, SUCCESSFUL HANDLING OF CASUALTY CLAIMS 5 (rev. ed. 1974); C. BRAINARD, *supra* note 5, at 511.

[25] *See, e.g.*, D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 110-11; R. MEHR & E. CAMMACK, *supra* note 6, at 550.

[26] *See* S. HUEBNER, *supra* note 10, at 631.

making and underwriting.[27] For example, claims payments are the most substantial cash drain on insurers, for which extensive loss reserves must be set aside.[28] Thus, the failure to determine claims accurately may imperil an insurer's solvency and necessitate higher rates for its insureds.[29] Indeed, insurers calculate premiums primarily on their experience in paying past losses and prediction of future losses.[30] Similarly, an insurer's underwriting capacity is significantly affected by the size of claims payments.[31] An insurer may therefore

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[27] *See generally* R. MEHR & E. CAMMACK, *supra* note 6, at 550, 629, 631, 638-39; C. BRAINARD, *supra* note 5, at 449-52; S. HUEBNER, *supra* note 10, at 631, 635, 667, 670.

[28] *See generally* P. MAGARICK, *supra* note 24, at 109. Insurers are required by state law to establish loss reserves for outstanding claims. *See, e.g.*, R. RIEGEL & J. MILLER, *supra* note 5, at 614-15; D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 185. Loss reserves are one of an insurer's principal financial liabilities. *See* R. MEHR & E. CAMMACK, *supra* note 6, at 625. Consequently, because of its impact on an insurer's reserve position, the claims adjustment process is one of the principal determinants of an insurer's financial stability and its ability to meet policyholder obligations. *See generally* R. MEHR & E. CAMMACK, *supra* note 6, at 558. S. HUEBNER, *supra* note 10, at 630-31; C. BRAINARD, *supra* note 5, at 522.

[29] *See, e.g.*, S. HUEBNER, *supra* note 10, at 635; D. BICKELHAUPT & J. MAGEE, *supra note* 5, at 111. *See also* C. CISSLEY, *supra* note 10, at 11; C. BRAINARD, *supra* note 5, at 449-52.

[30] A number of courts have recognized the direct impact of claims settlement practices on the determination of rates under various state-regulated ratemaking schemes. *See* Proctor v. State Farm Mut. Auto. Ins. Co., 406 F. Supp. 27, 29 & n.1 (D.D.C. 1975), *aff'd*, 561 F.2d 262 (D.C. Cir. 1977), *vacated and remanded*, 440 U.S. 942 (1979); Chick's Auto Body v. State Farm Mut. Auto. Ins. Co., *supra*, 401 A.2d at 727. *See also* Quality Auto Body v. Allstate Ins. Co., *supra*, 660 F.2d at 1201 n.4; Workman v. State Farm Mut. Auto. Ins. Co., *supra*, 520 F. Supp. at 615 n.7. For example, an insurer's claims adjustment policy has a direct impact on the "adequacy" of its rates under state ratemaking policy. *See generally*, C. BRAINARD, *supra*, note 5, at 449-52, 461-62; R. MEHR & E. CAMMACK, *supra* note 6, at 601; P. MAGARICK, *supra* note 24, at 13.

[31] *See generally* R. MEHR & E. CAMMACK, *supra* note 6, at 631; P. MAGARICK, *supra* note 24, at 109.

respond to a high loss ratio by restricting the scope of the risks it is willing to underwrite.[22]

An insurer can avoid these adverse consequences of excessive claims payments, while at the same time adequately reimbursing policyholders, only through recourse to information allowing accurate appraisal of losses. Collecting claims information thus has a direct impact on the insurer's reliability and on insurer-insured relationships, both individually and in the aggregate. This effect arises from factors quite different from the cost containment measures addressed in *Royal Drug*, for the impact of claims settlement practices arises directly out of the insurer's discharge of its obligations to insureds under the policy.

E. Use Of Third Party Sources Of Information In Claims Adjustment Does Not Vitiate The McCarran Act Exemption

In part, the decision of the Court of Appeals rests on an interpretation of *Royal Drug* as holding that the involvement of *any* noninsurer in insurance company practices—no matter what the extent or type of involvement—precludes those practices from becoming part of the "business of insurance." *See* 650 F.2d at 395. App. 18a. *Royal Drug*, however, did not adopt so mechanical a test. The Court looked, not to the mere fact of third party involvement, but to the nature and purpose of that involvement. *See* 440 U.S. at 216-17.

There are crucial differences between an insurer's request for claims information from third parties and the purchase of goods and services considered in *Royal Drug*. *Royal Drug* rejects the argument that third party purchase contracts are the "business of insurance" when-

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[22] *See* S. HUEBNER, *supra* note 10, at 631, 635. *See also* D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 111; C. BRAINARD, *supra* note 5, at 481-83.

ever they enable an insurer to control its costs, thereby reducing premiums and enhancing its status as a reliable insurer. *Id.* As the Court noted, that test provides no principled basis for distinguishing between purchase contracts and a wide variety of other business decisions which could minimize an insurer's costs, but which are not unique to the insurance business. *Id.* at 232 & n.40. Such a standard might extend the McCarran Act to shield anticompetitive activity in markets for noninsurance goods and services.

The collection of information and advice by an insurer in aid of claims settlement presents no such problems. First, and most obviously, the collection of information does not involve an agreement between the insurer and third parties to purchase goods and services for supply to its policyholders. The insured remains free to select a provider of his choice. Second, the information is collected solely for the use of the insurer in independently determining the amount it will pay to its insureds. The insurer does not determine prices in the market for the goods and services which the policyholder must purchase to repair or replace his property. With respect to automobile insurance, for example, repair shops remain free to set a price above or below the level used by insurers in calculating claims.

It must be emphasized that only the third party's act of providing information or assistance in claims settlement, upon request by an insurer, constitutes the "business of insurance." To the extent third parties misuse such information in *their* pricing decisions, or for other noninsurance purposes, such conduct would not be immune but would remain within the full reach of the Sherman Act.[33]

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[33] *See* Arizona v. Maricopa County Medical Soc'y, 643 F.2d 553 (9th Cir. 1980), *cert. granted*, 49 U.S.L.W. 3663 (Mar. 10, 1981). As several courts have recognized, the interest of the insurer is in minimizing claims payments, an objective antagonistic to the interest of providers in maximizing the prices they receive for their

II. THE LEGISLATIVE HISTORY OF THE McCARRAN ACT SUPPORTS THE INCLUSION OF CLAIMS ADJUSTMENT WITHIN THE "BUSINESS OF INSURANCE"

As this Court observed in *Royal Drug*, the McCarran Act "was enacted . . . in response to this Court's decision in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533." 440 U.S. at 217. *South-Eastern Underwriters* explicitly recognized that the business of insurance was a "single continuous chain of events," with one of the most important links in that chain being the payment of losses. 322 U.S. at 537, 541.

Congress, at the time the McCarran Act was enacted, similarly understood that the business of insurance was not limited to ratemaking and the sale of policies but also included the payment of losses.[34] In particular, Congress was aware of the existence of agreements and other joint activities among insurers regarding claims adjustment. Supporters of the Act considered these activities to be threatened by the decision in *South-Eastern Underwriters*.[35] The proponents of continued state regula-

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goods and services. *See, e.g.*, Quality Auto Body v. Allstate Ins. Co., *supra*, 660 F.2d at 1204-05; Proctor v. State Farm Mut. Auto. Ins. Co. (Proctor II), [1980-81] Trade Cas. (CCH) ¶ 63,591 at 77,141 (D.D.C. 1980), *appeal docketed*, No. 80-2437 (D.C. Cir. Nov. 14, 1980); Chick's Auto Body v. State Farm Mut. Auto. Ins. Co., *supra*, 401 A.2d at 732; DeBonaventura v. Nationwide Mut. Ins. Co., 419 A.2d 942, 951 (Del. Ch. 1980), *aff'd*, 428 A.2d 1151 (Del. S. Ct. 1981).

[34] *See, e.g.*, 90 CONG. REC. 6546 (1944) (remarks of Mr. Rolph): "The only time the average citizen needs or really pays any attention to an insurance policy is the day he suffers a loss." *Cf. id.* at 6536 (remarks of Mr. Howell): "Insurance is essentially a personal promise of indemnity by the insurer to the insured."

[35] Congressman Satterfield remarked that

> [a] great number of fire-insurance companies have cooperated in mutual agreement—and of necessity—through the Southeastern Underwriters Association and rating bureaus, adjust-

tion of insurance also recognized that claims adjustment was one of the critical elements in the relationship between the insurer and its insureds.[36] Furthermore, the collection of information for purposes of claims adjustment is fundamentally no different from the collection of statistical data on losses for ratemaking purposes, which, as this Court emphasized in *Royal Drug*, is the most important form of conduct that Congress intended to exempt from the antitrust laws.[37]

Of equal significance, the bill proposed by the National Association of Insurance Commissioners ("NAIC") in 1944 identified claims adjustment, and specifically adjustment agreements, as one of the elements of the business of insurance to which the Sherman Act would not apply. As this Court stated in *Royal Drug*, "[t]he views

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> ing policy rates to risks, . . . making appraisals of losses, and working out systems of inspection to improve protection against [losses]. All of this has been done with splendid success. It would be a pity indeed, after all of these years, to have the Government intervene.

90 CONG. REC. 6530. *Cf. id.* at 6551 (remarks of Congressman Ploesser, noting the efforts of insurance companies to improve claims services).

[36] Congressman Ploesser, speaking in favor of continued state regulation of insurance, observed that

> [p]rogress in insurance means several things: First, constant broadening of forms—policy coverage—second, constant lowering of rates in accordance with sound competition and in keeping with sound financial structure; and third, constant improvement in *servicing of claims* and engineering.

90 CONG. REC. 6550 (emphasis added). *Cf. id.* at 6543 (remarks of Mr. Jennings): "The people of this country carry insurance for protection. And under State control they are getting and will continue to receive the value of their property when it burns." *See also id.* at 6530 (remarks of Mr. Satterfield). Congress recognized that insurance contracts are unique in that they are carried out "long after they are written and long after the policyholders have paid their money to the company." *Id.* at 6564 (remarks of Mr. Vorys). *See also id.* at 6526 (remarks of Mr. Hancock).

[37] *See* 440 U.S. at 222.

of the NAIC are particularly significant, because the Act ultimately passed was based in large part on the NAIC bill." 440 U.S. at 221.[38]

Finally, as the Court acknowledged in *Royal Drug*, the legislative history of the McCarran Act, when viewed in light of the decision in *South-Eastern Underwriters*, can be read to support the proposition that Congress intended to include "transactions between an insurer and its agents, including independent agents" within the Act's exemption. 440 U.S. at 224 n.32.[39] At the time the McCarran Act was enacted, agents, including independent agents, functioned as claims adjusters.[40] In providing

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[38] *See* NAIC Report and Proposed Bill, 90 CONG. REC. A4403, A4406 (1944). The law as ultimately enacted did not include a specific list of exempt activities. *See* 440 U.S. at 222 n.28. However, unlike the provider agreements in *Royal Drug*, which were not identified in the NAIC bill, *see id.* at 223 & n.30, claims adjustment was specifically mentioned in the NAIC proposal. Therefore, inclusion of claims adjustment within the "business of insurance" would not extend the scope of the exemption beyond that which Congress may reasonably be said to have contemplated based on the proposals before it. Conversely, there is no indication in the legislative record of a congressional intent to *exclude* claims adjustment from the "business of insurance." Thus, to construe the exemption as finally enacted as reflecting a congressional intent to exclude claims adjustment would effectively deny McCarran Act coverage to *all* of the activities enumerated in the NAIC bill—practically all of the business of insurance, including ratemaking.

[39] *See generally* Robertson v. California, 328 U.S. 440 (1946); Brief of the Solicitor General, *supra* note 16, at 26 n.14. *See also* Bartholomew v. Virginia Chiropractor's Ass'n, 612 F.2d 812, 817 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980).

[40] *See generally* Butler, *supra* note 6, at 219-20; W. MOORE, *supra* note 8, at 11-12. Congress was fully aware of this practice at the time it enacted the McCarran Act. *See* 90 CONG. REC. 6538 (1944) (remarks of Mr. Celler). Over time, claims adjustment has increasingly been performed by professional adjusters, rather than sales agents, although some insurers continue to allow sales agents to adjust small claims today. *See* S. HUEBNER, *supra* note 10, at 633; D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 112.

claims information and advice to insurers, peer review groups perform a function similar to that performed by an insurer's claims adjusters.[41] Thus, third parties, like peer review groups, whose relationship with insurers is confined to providing information which the insurer requires before paying claims, operate in a role of the sort that the McCarran Act was designed to protect.

In sum, the legislative history strongly suggests that Congress, at the time it considered the McCarran-Ferguson Act, intended that claims adjustment practices be part of the "business of insurance."

III. LONGSTANDING STATE REGULATION OF CLAIMS ADJUSTMENT CONFIRMS THAT IT IS PART OF THE BUSINESS OF INSURANCE AND WOULD BE JEOPARDIZED BY THE DECISION BELOW

Congress' primary concern "in the wake of [*South-Eastern Underwriters*] was in enacting legislation that would ensure that the states would continue to have the ability to tax and regulate the business of insurance." *Group Life & Health Insurance Co. v. Royal Drug Co.*, *supra*, 440 U.S. at 217-18. In view of Congress' intent, the existence of state regulation of claims adjustment both prior to and following the passage of the McCarran Act provides further confirmation that it is part of the "busi-

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[41] The claims adjuster has been characterized as "the connecting link between the insurance company and the insured," W. MOORE, *supra* note 8, at 7, and as "the 'spokesman' for the insurance policy, and the representative of the insurance industry in the eyes of insureds." Butler, *supra* note 6, at 222. Insurers generally utilize one or more types of adjusters in settling claims: sales agents, staff adjusters, independent or fee adjusters and adjustment bureaus. However, the function performed by the claims adjuster is identical *regardless* of the nature of his employment relationship with the insurer. *See, e.g.*, R. MEHR & E. CAMMACK, *supra* note 6, at 558; D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 112-15; Butler, *supra* note 6, at 226.

ness of insurance" "within the ordinary understanding of that phrase . . . ." *Id.* at 211.[42]

State insurance commissioners, relying primarily on their licensing, investigatory and general powers to protect the insuring public, supervised claims practices well before the decision in *South-Eastern Underwriters.*[43] As one authority has commented regarding state regulation during that period:

> The Commissioner [of Insurance] also quite commonly has the power to *investigate complaints*: of rate violations, underwriting practices, . . . of *claim practices*, of practically every aspect of the insurance business.[44]

This supervision of claims settlement by state officials was based on a recognition that an insurer's claims settlement practices were a "matter of vital importance" to insureds,[45] and affected the insurer's reliability as significantly as did its solvency.[46]

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[42] *See generally* 440 U.S. at 225-30.

[43] *See* E. PATTERSON, THE INSURANCE COMMISSIONER IN THE UNITED STATES 283-87, 295-306 (1927); STATE OF NEW YORK, SEVENTY-EIGHTH ANNUAL REPORT OF THE SUPERINTENDENT OF INSURANCE, pt. I at 58 (1937). *See also* C. KULP, CASUALTY INSURANCE 651-52 (rev. ed. 1942); I *Proceedings of the NAIC* at 181 (1911); II *Proceedings of the NAIC* at 7-8 (1911).

[44] C. KULP, *supra* note 43, at 610-11 (second emphasis added). *Cf. Insurance: Joint Hearings on H.R. 3270 Before the Subcomms. of the Comms. on the Judiciary*, 78th Cong., 1st Sess. 239, 245 (1943) (letters from insurance commissioners supporting continued state regulation and suggesting that the experience in other states was similar). *See also* E. PATTERSON, *supra* note 43, at 445. Patterson concludes that oversight of claims settlement was a function "inevitably thrust upon [the Insurance Commissioner] by his relations with the insuring public . . . ." *Id.* at 285.

[45] SEVENTY-EIGHTH ANNUAL REPORT OF THE SUPERINTENDENT OF INSURANCE, *supra* note 43, at 58.

[46] In the words of one state official of the pre-*South-Eastern Underwriters* period: "The public sees no reason to distinguish

In addition, the NAIC bill, put before Congress shortly after the decision in *South-Eastern Underwriters*, provided for the exemption of the business of insurance from the Federal Trade Commission Act ("FTC Act").[47] This proposal was based on the theory that the states were already "empowered to deal with improper practices," including "sharp claims practices."[48]

In the period immediately following passage of the McCarran Act, the states were invited to enact additional regulatory statutes.[49] Responding to Congress' invitation, the NAIC approved a Model Uniform Unfair Trade Practices Act patterned after the FTC Act but specifically applicable to insurance.[50] The Model Act expressly covered adjusters and authorized the state insurance commissioner to define, investigate and apply to the state attorney general for cease and desist orders regarding "unfair methods of competition" or "unfair or deceptive acts or practices" in areas such as claims adjustment.[51] All 50 states and the District of Columbia subsequently enacted the NAIC Model Act or statutes based on it.[52] The Model

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between protection from loss through the companies becoming insolvent and protection from loss through the failure of a company to settle a claim as the insured thinks it should be settled." Remarks of Mr. James Wood, New York Bureau of Claims, *quoted in* E. PATTERSON, *supra* note 43, at 284 n.2. State supervision of claims settlement was not limited to failure to pay claims, but also extended to the overly liberal payment of claims because of inadequate claims investigation by insurers. *See id.* at 303-06.

[47] *See* NAIC Report and Proposed Bill, 90 CONG. REC. A4403, A4406-07 (1944).

[48] *Id.* at A4405.

[49] *See* 15 U.S.C. § 1013(a), providing for a three-year moratorium during which the federal antitrust laws would not apply to insurance.

[50] *Proceedings of the NAIC* 392, 413 (1947).

[51] *Id.* at 392, 398-99.

[52] *See* 1 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, MONITORING COMPETITION: A MEANS OF REGULATING THE PROPERTY

Act was later amended to enumerate specific unfair claims settlement practices and to strengthen the enforcement powers of the state insurance commissioner.[53] Most of the states have now adopted these additional provisions of the Model Act.[54]

In view of the states' long oversight of claims practices, the suggestion of the Court of Appeals that claims adjustment is not part of the "business of insurance" is inconsistent with the underlying purpose of the McCarran Act. Congress' objective in enacting the McCarran Act was to allow the states to continue to regulate that which they had regulated prior to *South-Eastern Underwriters* and to leave future regulation of insurance primarily in the hands of the states, rather than the federal government.[55] At present, and as Congress intended, the states are empowered to regulate the entire insurance relationship and do so with an eye toward the totality of that relationship.

This would no longer be the case under the decision below. The states would be left in the anomalous position of being able to regulate only the "front-end" of the relationship between the insurer and the insured, namely, matters such as ratemaking, policy approval[56] and the

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AND LIABILITY INSURANCE BUSINESS 222 (1974) (hereinafter NAIC). By 1955, 44 states had adopted the Model bill or a statute "essentially the same." *See* FTC v. National Cas. Co., 357 U.S. 560, 564 n.6 (1958) (*per curiam*).

[54] *See* I *Proceedings of the NAIC* 493 (1972). *See also* 1 NAIC, *supra* note 52, at 221 n.597; P. THOMAS & P. REED, *supra* note 19, at 18.

[54] *See* C. HUEBNER, *supra* note 10, at 633.

[55] See Group Life & Health Ins. Co. v. Royal Drug Co., *supra*, 440 U.S. at 218 n.16, citing H.R. Rep. No. 143, 79th Cong., 1st Sess. 2-3 (1945).

[56] State regulation of fire insurance policy provisions dates back to the late 19th century. *See, e.g.*, R. RIEGEL & J. MILLER, *supra* note 5, at 434; E. PATTERSON, *supra* note 43, at 247-49. Indeed, the states went so far as to prescribe explicitly the terms of fire

sale and advertising of policies—but not claims adjustment, a matter of at least equal importance to *both* the insurer and the insured.[57] The resulting prospect is one of inconsistent regulatory standards as between ratemaking and claims adjustment, a particularly troubling prospect considering the fact that premium rates are principally dependent on the insurer's and the industry's past and predicted experience in paying claims.[58] Contrary to Congress' intent, insurers would risk exposure to the federal antitrust laws if they attempted to utilize claim

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insurance policies, including provisions limiting the amount of risk the insurer agrees to assume to the "actual cash value" of the property. *See* D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 235; R. RIEGEL & J. MILLER, *supra* note 5, at 435, 442-45. The practice of state prescription of fire insurance policy provisions reached a climax in 1943, prior to the decision in *South-Eastern Underwriters*, with the adoption in New York, and thereafter in practically all of the other states, of the New York Standard Fire Insurance Policy. *See, e.g.*, D. BICKELHAUPT & J. MAGEE, *supra* note 5, at 182, 230; R. RIEGEL & J. MILLER, *supra* note 5, at 434. The long and continuing history of state approval or prescription of policy provisions specifying benefits in terms which are indeterminate at the time the policy is issued, further supports the proposition that claims adjustment, as the process which defines and quantifies those benefits, was considered to be part of the business of insurance at the time the McCarran Act was adopted.

[57] If claims adjustment is not the "business of insurance" within the meaning of § 2(b) of the Act, then both the Sherman and the FTC Acts (including the latter's nonantitrust consumer protection provisions, *cf.* FTC v. National Cas. Co., *supra*, 357 U.S. 560) would apply to insurance and would prevail over any inconsistent state regulation on the same subject. *Cf.* SEC v. National Secs. Inc., 393 U.S. 453 (1969). *See generally* Mertz, *Commentary on Insurance Regulation Under the Commerce Clause, Proceedings, ABA Section of Insurance, Negligence and Compensation Law* 153, 168, 170-71, 194-99 (1964); *Consumer Protection Act of 1970: Hearings on S.3201 Before the Comm. on the Judiciary*, 91st Cong., 2d Sess. 149 (1970) (testimony of Richards D. Barger, Insurance Comm. of the State of California on Behalf of the National Association of Insurance Commissioners), *reprinted in* I *Proceedings of the NAIC* 135 (1971).

[58] *See* nn.29-30 *supra*.

settlement practices to control claims costs consistent with the policies of state law and state ratemaking officials.[59] If allowed to stand, the decision of the Court of Appeals would cast a pall of uncertainty over existing state regulation akin to that engendered by *South-Eastern Underwriters*—and thus resurrect the very evil Congress sought to cure in enacting the McCarran Act.

CONCLUSION

For the reasons set forth above, the *amici curiae* urge that the judgment of the Court of Appeals be reversed.

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[59] *See generally* Chick's Auto Body v. State Farm Mut. Auto. Ins. Co., *supra*, 401 A.2d at 725-27.

Amicus Brief

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In the Supreme Court

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United States

OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY and
NEW YORK STATE CHIROPRACTIC ASSOCIATION,
PETITIONERS,

VS.

A. ALEXANDER PIRENO,
RESPONDENT.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE STATES OF ARIZONA, ARKANSAS, COLORADO, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, LOUISIANA, MARYLAND, MICHIGAN, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEW MEXICO, NORTH CAROLINA, OHIO, RHODE ISLAND AND PROVIDENCE PLANTATIONS, TEXAS, UTAH, VERMONT AND WISCONSIN AS AMICI CURIAE

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In the Supreme Court

OF THE

United States

OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY and
NEW YORK STATE CHIROPRACTIC ASSOCIATION,
PETITIONERS,

VS.

A. ALEXANDER PIRENO,
RESPONDENT.

BRIEF OF THE STATES OF ARIZONA, ARKANSAS, COLORADO, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, LOUISIANA, MARYLAND, MICHIGAN, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEW MEXICO, NORTH CAROLINA, OHIO, RHODE ISLAND AND PROVIDENCE PLANTATIONS, TEXAS, UTAH, VERMONT AND WISCONSIN AS AMICI CURIAE

The States of Arizona, Arkansas, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Louisiana, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Carolina, Ohio, Rhode Island and Providence Plantations, Texas, Utah, Vermont and Wisconsin respectfully submit this brief amici curiae pursuant to Supreme Court Rule 42(4).

INTEREST OF THE AMICI STATES

Expenditures for health care now represent approximately 10 percent of the gross national product and the cost of these services is escalating at a rate far in excess of the general rate of inflation in other sectors of the economy.[1] The States are vitally concerned with this problem both in their proprietary capacities as major purchasers of health care services and in their governmental capacities as the primary regulators of this sector of the economy. As part of their efforts to reduce rampant inflation in health care costs, the States have actively sought to enforce the antitrust laws to introduce a needed measure of competition to both health care[2] and insurance.[3] This Court's decision on

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[1]*See generally* Juba, *Price Setting in the Market for Physicians' Services: A Review of the Literature*, Health Care Financing Grants and Contracts Report (Health, Educ. & Welfare Pub. No. (HCFA) 03012 9-79, 1979); Freeland, Calat and Schendler, *Projections of National Health Expenditures, 1980, 1985 and 1990*, 1 Health Care Financing Review, No. 3, 1-27 (1980); National Health Survey, Dept. of Health, Educ. & Welfare, *Family Out-of-Pocket Health Expenses, United States 1975*, (Public Health Service Pub. No. 51. 1979); Senate Committee on Governmental Affairs, *The California Relative Value Studies, An Overview*, 96th Cong., 1st Sess. (1979).

[2]*See, e.g., Arizona v. Maricopa County Medical Society*, No. 80-419 *on cert. from* 643 F.2d 553 (9th Cir. 1980); *Ohio ex rel. Brown v. Greater Cleveland Hospital Ass'n*, 1981-1 CCH Trade Cas. ¶ 64,113 (N.D. Ohio 1981); *New York v. American Medical Ass'n*, 1980-2 CCH Trade Cas. ¶ 63,456 (E.D.N.Y. 1980); *Ohio ex rel. Brown v. Mahoning County Medical Society*, 1980-1 CCH Trade Cas. ¶ 63,100 (N.D. Ohio 1979); *Arizona ex rel. Corbin v. Arizona Radiological Society*, 1979-1 CCH Trade Cas. ¶ 62,683 (Ariz. Super. Ct. 1979); *Massachusetts ex rel. Bellotti v. Massachusetts Nurses Ass'n*, 1980-2 CCH Trade Cas. ¶ 63,304 (Mass. Super. Ct. 1980); *Michigan v. Warner-Universal Ambulance Service*, 1980-2 CCH Trade Cas. ¶ 63,536 (Mich. Cir. Ct. 1980); *New Jersey v. Nurses Private Duty Registry, Inc.*, 1977-2 CCH Trade Cas. ¶ 61,809 (N.J. Super. Ct. 1977); *New York v. Empire City Pharmaceutical Society, Inc.*, 1978-2 CCH Trade Cas. ¶ 62,383 (N.Y. Sup. Ct. 1978).

[3]*See, e.g., Arizona v. Title Insurance Rating Bureau of Arizona, Inc.*, 517 F. Supp. 1053 (D. Ariz. 1981); *Ohio v. Ohio Medical Indemnity, Inc.*, 1976-2 CCH Trade Cas. ¶ 61,128 (S.D. Ohio 1976), 1978-2 CCH Trade Cas. ¶ 62,154 (S.D. Ohio 1978).

the scope and the meaning of the McCarran-Ferguson exemption, 15 U.S.C. § 1011 *et seq.*, will have a manifest impact on the States' ability to invoke competitive forces of the marketplace as a remedy for burgeoning health care costs.

The predominance of third-party reimbursement mechanisms in the health care sector has weakened normal economic forces which might otherwise operate to hold down price increases.[4] The prevalence of payment schemes pegged to "uniform, customary and reasonable" fees or predicated upon cost reimbursement acerbates the problem.[5] If the inflationary spiral is to be halted, the solution lies in minimizing the effect of these distortions. Positive incentives for cost-containment should and must be created to replace the disincentives which now exist. While there is no shortage of current legislative proposals to create such positive incentives, there is inherent in the legislative approach a degree of rigidity that would not be present if the antitrust laws were to apply and the forces of the marketplace were given an opportunity to operate.

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[4]*See generally* Havighurst, *Antitrust Enforcement in the Medical Services Industry: What Does It All Mean?* 58(1) MILBANK MEMORIAL FUND QUARTERLY 89 (1980); Newhouse, *Inflation and Health Insurance*, in R. Luke & J. Bauer, ISSUES IN HEALTH ECONOMICS (1982).

[5]Despite the superficial appeal of its name, the "uniform, customary and reasonable" method of reimbursement can operate as a positive incentive to inflated health costs. Under this system, a provider has a strong incentive to increase his or her billing rates so that UCR rates are increased over time. If enough providers in the community do this, the area's customary change is also raised. *See generally* Lee & Hadley, *Physicians' Fees and Public Medical Care Program*, 16(2) HEALTH SERVICES RESEARCH 185 (1981); Showstack, *Fee-for-Service Physician Payment: Analysis of Current Methods and their Development*, 16(3) INQUIRY 231, 234-36 (1979).

In appropriate circumstances, peer review systems may be one means for lowering costs.[6] Peer review can take two forms. It can be a means of reviewing the propriety of medical services rendered by a health care provider and it can be a means of judging the appropriateness of the price charged. In the present case, the arrangement between petitioners Union Labor and NYSCA apparently serves both functions. It operates to deny respondent Pireno any insurance reimbursement whatsoever for medical services disapproved by members of NYSCA and it attempts to reduce the allegedly excessive fees he charges.

Neither the legality of petitioners' peer review system nor the amount of respondent's damages, if any, is now before this Court, however, and petitioners' presumedly beneficient purpose is no justification for totally exempting this or analogous arrangements from any antitrust scrutiny whatsoever. Precisely because "conduct which is not exempt from the antitrust laws may nevertheless be perfectly legal," *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210 n.5 (1979), the exemption should not turn on the legality of the underlying conduct. What is claimed to be a legitimate peer review system may actually prove to be a scheme to establish a uniform price schedule[7] or a

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[6]Congress has, for example, provided for the creation of professional standards review organizations, 42 U.S.C. § 1320c *et seq.*, to review the medical necessity of certain federally-funded medical treatment. The intended purpose of this legislation was "to promote the . . . economical delivery of health care services." 42 U.S.C. § 1320c. Whether professional standards review organizations have actually served the purposes for which Congress created them is currently a subject of lively debate.

[7]*See, e.g., Albrecht v. Herald Co.*, 390 U.S. 145, 153 (1968) ("if the actual price charged under a maximum price scheme is nearly always the fixed maximum price . . . that scheme tends to acquire all the attributes of an arrangement fixing minimum prices"); *Quinn v. Mobile Oil Co.*, 375 F.2d 273, 277-78 (1st Cir. 1967) (Coffin, J., concurring) ("an identical or parallel system of maximum prices between [competitors] is likely to become a system of minimum prices"). The agreement between the medical association and the insurers which is before this Court in *Maricopa County* is said to have this effect of establishing a uniform price schedule for competing physicians. *See* Brief for Petitioner at 7-12, *Arizona v. Maricopa County Medical Society*, No. 80-419.

thinly-veiled guise for a boycott of competing health care providers.[8] The issue here is the threshold one whether the McCarran-Ferguson Act completely shields from any antitrust scrutiny all agreements between health-care providers and insurers. Because this Court's decision will affect the States' ability to examine such arrangements under the antitrust laws, it is of vital importance.

In the present case, NYSCA's peer review process can be invoked by a provider who claims that he has been paid too little, *see* CA2 J.A. A-29, A-53, and in certain circumstances the insurer may become bound to pay the higher amount demanded by the provider. *Id.*, at A-28. In at least some circumstances, therefore, petitioners' peer review system can and actually has increased the prices paid for medical services.

[8]*See, e.g., McReady v. Blue Shield*, 649 F.2d 228 (4th Cir. 1981); *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (4th Cir. 1980) (agreement between psychiatrists and insurer to deny insurance reimbursement to licensed psychologists); *Ballard v. Blue Shield*, 543 F.2d 1075 (4th Cir. 1976) (agreement between medical doctors, their association and insurer to deny insurance reimbursement to licensed chiropractors); Brief for Petitioner at 6 n.5, *Arizona v. Maricopa County Medical Society*, No. 80-419 (agreement between medical doctors, their association and insurers to limit insurance reimbursement to specified categories of licensed health care providers).

Viewing the evidence in the present case in the light most favorable to respondent as this Court must do on petitioners' motions for summary judgment, *cf. Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738, 740 (1976), there is evidence to support a finding of a comparable agreement among petitioners to deny respondent insurance reimbursement for certain services. Petitioners' peer reveiw system was begun at the initiative of NYSCA, CA2 J.A. A-23 to -24, A-34 to -36, in furtherance of NYSCA's members' financial "self-interest." *Id.*, at A-23. NYSCA's peer review guidelines recommend disallowance of any "third-party payment for vitamins, blood tests, urinalyses, injectables or acupuncture." Upon the trial of this matter, respondent may be able to prove that these limitations on reimbursement are the same sort of unlawful boycott that occurred in *McCready*, *Virginia Academy* and *Ballard*.

There is another and more fundamental reason underlying the States' interest. The McCarran-Ferguson Act is, at bottom, an accommodation to the different roles of State and Federal law. It was enacted in the wake of *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944), to avoid any possible invalidity of State laws under the Commerce Clause. *See St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 538-39 (1978); *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 458-59 (1969); *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429-31 (1946). Thus, Congress found "that the continued regulation and taxation by the several States of the business of insurance is in the public interest." 15 U.S.C. § 1011. Accordingly, Congress provided that "[t]he business of insurance . . . shall be subject to the laws of the several states," 15 U.S.C. § 1012(a), and that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b). Conversely, Congress provided for the continued application of federal laws which "specifically relate to the business of insurance" and for the continued application of federal antitrust laws "to the business of insurance to the extent that such business is not regulated by state law." *Ibid.* And, finally, the supremacy of federal over state law was preserved in the case of "boycott, coercion or intimidation." 15 U.S.C. § 1013(b). *See generally* Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 Duke L.J. 587. The McCarran-Ferguson Act therefore carefully delineated the respective roles of the State and Federal Governments and the States have a vital interest in this Court's consideration of this basic issue of federalism.

SUMMARY OF ARGUMENT

To qualify for the McCarran-Ferguson antitrust exemption, petitioners must satisfy three independent crite-

ria. First, they must show that their activities constitute "the business of insurance." *See Group Life & Health Ins. Co. v. Royal Drug Co., supra.* Second, petitioners will only be entitled to the exemption "to the extent" that their activities are "regulated by state law." *See Federal Trade Commission v. National Casualty Co.*, 357 U.S. 560 (1958). Finally, even if the other criteria are met, the exemption will not be available if the conduct involves an "agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation." *See St. Paul Fire & Marine Ins. Co. v. Barry, supra.*

Because this case is here on petitioners' motions for summary judgment all facts must be viewed in the light most favorable to respondent. *E.g., Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738, 740 (1976); *Zelson v. Phoenix Mutual Life Ins. Co.*, 549 F.2d 62 (8th Cir. 1977). Viewed by this standard, petitioners' factual showing falls far short of that required to satisfy any of the elements of the McCarran-Ferguson exemption. An insurer's utilization of the peer review services of a professional society is not "the business of insurance" because, at best, the conduct involves nothing more than an effort to reduce the insurer's expenditures and increase its profits and does not involve any underwriting of risks or investment risk-taking by the insurer. Even if such conduct performed solely by an insurer could be considered to be the "business of insurance," the statutory exemption would not apply here because of the involvement of an entity outside the insurance industry which is not shielded by the McCarran-Ferguson Act. Further, the State of New York neither compels nor actively supervises petitioners' conduct thereby failing the second test for the exemption. Finally, petitioners' activity is a concerted effort to deny respondent monetary benefits and is therefore a boycott which is not entitled to an exemption.

ARGUMENT

I. AN AGREEMENT BETWEEN AN INSURER AND AN ASSOCIATION OF PROVIDERS SETTING THE REIMBURSEMENT LEVEL FOR PROVIDERS IS NOT THE "BUSINESS OF INSURANCE" WITHIN THE MEANING OF THE McCARRAN-FERGUSON ACT

The Second Circuit's decision in *Pireno v. New York State Chiropractic Association*, 650 F.2d 386 (2d Cir. 1981), conflicts with the Fourth Circuit opinion in *Bartholomew v. Virginia Chiropractors Association*, 612 F.2d 812 (4th Cir. 1979), *cert. denied* 446 U.S. 938 (1980).[9] The Second Circuit, however, faithfully followed *Royal Drug* and this Court's other decisions interpreting the McCarran-Ferguson Act. Nothing said by the Fourth Circuit in *Bartholomew*, or petitioners or any of the *amici* here justifies departing from *Royal Drug*. The Second Circuit correctly applied *Royal Drug* and this Court should resolve the conflict in the circuits by affirming the Second Circuit and disapproving *Bartholomew*.

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[9]The Fifth, Eighth and Ninth Circuits are all in agreement with the Second Circuit's interpretation of *Royal Drug* that provider agreements are beyond the scope of the McCarran-Ferguson Exemption. *National Gerimedical Hospital and Gerontology Center v. Blue Cross*, 628 F.2d 1050 (8th Cir. 1980), *aff'g* 479 F. Supp. 1012 (W.D. Mo. 1979) *rev'd on other grounds*, ____U.S. ____, 101 S. Ct. 2415 (1981); *St. Bernard Hospital v. Hospital Service Ass'n*, 618 F.2d 1140 (5th Cir. 1980); *Arizona v. Maricopa County Medical Society*, 1979-1 CCH Trade Cas. ¶ 62,694 (D. Ariz. 1979), *aff'd* 643 F.2d 553 (9th Cir. 1980), *cert. granted* ____ U.S. ____, 101 S. Ct. 1512 (1981); *see also Hoffman v. Delta Dental Plan*, 1981-1 CCH Trade Cas. ¶ 64,138 (D. Minn. 1981).

No other Circuit Court has reached the same result as the Fourth Circuit in *Bartholomew*. Two decisions handed down the same day by a single District Judge in Oregon have been cited as following *Bartholomew*, *Hahn v. Oregon Physicians' Services*, 508 F. Supp. 970 (D. Ore. 1981); *Klamath Lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau*, 507 F. Supp. 980 (D. Ore. 1981); but these decisions are in conflict with the Ninth Circuit's contrary interpretation of *Royal Drug* in *Maricopa County*. *Health Care Equalization Committee v. Iowa Medical Society*, 501 F. Supp. 970 (S.D. Iowa 1980), is then the only case outside of the Fourth Circuit to follow *Bartholomew* and the dearth of reasoning in that case makes its precedential value suspect.

A. The Second Circuit Correctly Applied *Royal Drug* in Holding that Peer Review Systems Are Not the "Business of Insurance"

In sharp contrast to a great many of the lower court decisions which have been quick to grant an antitrust exemption to anything even tangentially connected with the insurance industry,[10] this Court has consistently given the McCarran-Ferguson Act a strict interpretation.[11] The decisions of this Court have not attempted to articulate any single talisman for determining what constitutes "the busi-

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[10]*See, e.g., Group Life & Health Ins. Co. v. Royal Drug Co., supra,* 440 U.S., at 208 n.2 (collecting cases); *St. Paul Fire & Marine Ins. Co. v. Barry, supra,* 438 U.S., at 536 n.5 (collecting cases).

[11]In *Group Life & Health Ins. Co. v. Royal Drug Co., supra, St. Paul Fire & Marine Ins. Co. v. Barry, supra, Securities and Exchange Commission v. National Securities, Inc., supra, Securities and Exchange Commission v. United Benefit Life Ins. Co.,* 387 U.S. 202 (1967), *Federal Trade Commission v. Travelers Health Ass'n,* 362 U.S. 293 (1960), and *Securities and Exchange Commission v. Variable Annuity Life Ins. Co., supra,* this Court upheld the application of federal statutes over the objection that the McCarran-Ferguson Act had preempted federal law. In *Federal Trade Commisson v. National Casualty Co.,* 357 U.S. 560 (1958), *aff'g National Casualty Co. v. Federal Trade Commission,* 245 F.2d 883 (6th Cir. 1957), and *American Hospital and Life Ins. Co. v. Federal Trade Commission,* 243 F.2d 719 (5th Cir. 1957), this Court upheld the jurisdiction of the Federal Trade Commission in those cases where States had not enacted prohibitory legislation and held that the McCarran-Ferguson Act preempted that jurisdiction where the States had enacted statutes specifically dealing with the same practices being examined by the Commission.

None of the other McCarran-Ferguson cases to come before this Court dealt with the interplay of State and federal statutes. Thus, *State Board of Insurance v. Todd Shipyards Corp.,* 370 U.S. 451 (1962), *Wilburn Boat Co. v. Fireman's Fund Ins. Co.,* 348 U.S. 310 (1955), and *Prudential Ins. Co. v. Benjamin,* 328 U.S. 408 (1946), all dealt with State regulatory or taxation powers which had been preserved by section 2(a) of the McCarran-Ferguson Act and did not implicate any conflicting federal statutes. *Maryland Cas. Co. v. Cushing,* 347 U.S. 409 (1954), and *Robertson v. California,* 328 U.S. 440 (1946), were both cases where this Court held that the McCarran-Ferguson Act was not applicable.

ness of insurance," however. Rather, this Court has formulated a series of cumulative standards based on the facts of the individual cases that have come here for decision. The error of the lower courts that have given the McCarran-Ferguson exemption too expansive a reading and, indeed, the basic fallacy of petitioners' arguments has been in reading this Court's decisions in isolation rather than as the threads of a larger tapestry defining the scope of the exemption.

In *Securities and Exchange Commission v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959), for example, this Court held that to qualify as "the business of insurance" there must be both "some investment risk-taking on the part of the company," *id.*, at 71, and also a "true underwriting of risks, the one earmark of insurance as it has commonly been conceived of in popular understanding and usage." *Id.*, at 73. Since the annuity contracts involved neither any investment risk-taking by the insurer nor any actuarial spreading of risks, this Court held that they were not "the business of insurance." *Accord, Securities and Exchange Commission v. United Benefit Life Ins. Co.*, 387 U.S. 202 (1967).

Securities and Exchange Commission v. National Securities, Inc., 393 U.S. 453 (1969), was in the same vein. *National Securities* was a case involving a merger between two companies concededly engaged in "the businss of insurance," "investment risk-taking" and the "true underwriting of risks." This Court nonetheless refused to apply the McCarran-Ferguson exemption because the merger did not touch upon the relationship between the insurance companies and their policyholders. *National Securities* did not abandon or reject the factors which had been dispositive in *Variable Annuity*. Quite the contrary, *National Securities* cited and approved *Variable Annuity*. 393 U.S., at 461. Rather, *National Securities* involved the identification of further criteria in addition to those in *Variable Annuity*

which must also be met to qualify for the McCarran-Ferguson exemption.

Group Life & Health Ins. Co. v. Royal Drug Co. involved an arrangement like the ones here and in *Bartholomew* by which a health insurer either reimbursed policyholders for services they received or made direct payments to providers for those services. In *Royal Drug, Bartholomew* and this case, the agreements in question were between the insurer and the provider. Applying the well-settled rule "that exemptions from the antitrust laws are to be narrowly construed," 440 U.S., at 231, and following the narrow interpretation of the McCarran-Ferguson Act in *Variable Annuity* and *National Securities*, this Court held that such arrangements were not "the business of insurance." Reasoning that "the underwriting or spreading of risk is a critical determinant in identifying insurance," *id.*, at 213, this Court held that the pharmacy agreements were not the "business of insurance" but were instead simply an effort "to minimize costs and maximize profits," *id.*, at 214, even though they might affect "the level of premiums charged . . . policyholders." *Id.*, at 215. To the same effect and relying upon *National Securities*, this Court held that provider agreements did not involve the relationship " 'between insurer and insured' . . . [but were instead] separate contractual arrangements between Blue Shield and pharmacies engaged in the sale and distribution of goods and services other than insurance," *id.*, at 216, and for this additional reason were outside the scope of the exemption. Finally, this Court dismissed the argument that the provider agreements affected the "reliability, interpretation, and enforcement" of the insurance contract by noting that the "argument . . . proves too much" and that the same could be said for virtually anything which affected the profitability of the insurer. *Id.*, at 216-17.

The Second Circuit in *Pireno* correctly followed and applied this Court's reasoning in *Royal Drug* while the

Fourth Circuit in *Bartholomew* did not.[12] The Second Circuit analyzed petitioners' conduct and found "neither risk transference nor risk spreading in the peer review process" because it "takes place only after the risk has been transferred by means of the policy, and then it functions only to determine whether the risk of the entire loss (the insured's cost of treatment) has been transferred to the insurer." 650 F.2d, at 393. Accordingly, like this Court had done in *Royal Drug*, the Second Circuit concluded that "peer review is simply a form of cost reduction." *Ibid.* To the same effect, the Second Circuit compared the pharmacy agreements in *Royal Drug* with petitioners' peer review system and found "no meaningful difference between the effects on the insurer-insured relationship in *Royal Drug* and in the present case." *Id.*, at 394. It therefore declined to follow *Bartholomew*, *id.*, at 395 n.13, and instead concluded that the criteria for the McCarran-Ferguson exemption had not met.

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[12]Even under the rationale of the *Royal Drug* dissent, petitioners' activities in this case are outside the McCarran-Ferguson exemption. Justice Brennan's dissent considered two characteristics of the *Royal Drug* provider agreements to be sufficient to qualify them for the exemption: "they (1) directly obtain the very benefits promised in the policy . . . and (2) themselves constitute a critical element of risk 'prediction.' " 440 U.S., at 252-53. Even where these characteristics were present, however, Justice Brennan recognized that additional factors might forfeit the exemption as in "a case where the petitioner pharmacies themselves conspired to exclude others from the market, and either pressured Blue Shield to go along, or were voluntarily joined by the insurer." *Id.*, at 253.

Since the peer review system comes into play only after the insurance policy has been written and the services have been performed and since the determination of the appropriateness of the medical service and the price for that service are both made after the fact as of the time that the service was performed, the peer review system neither "obtains . . . the benefits promised in the policy" nor can it operate as an "element of risk 'prediction.' " In any event, the peer review system here fits precisely Justice Brennan's paradigm of a case that would not qualify for the exemption from the antitrust laws. *See* notes 7 and 8, *supra*.

In *Bartholomew*, by contrast, a divided panel of the Fourth Circuit considered it sufficient that "each defendant's activities *touched upon* 'the business of insurance,' " 612 F.2d, at 817 (emphasis added), even though the decisions in *Variable Annuity, National Securities* and *Royal Drug* all held that more than a tangential relationship to the business of insurance was required to qualify for the McCarran-Ferguson exemption. The *Bartholomew* majority distinguished *Royal Drug* saying that it involved "two segregated and disparate operations, . . . the offering of insurance and . . . the procurement of drugs" while it considered the peer review system before it to be "a single, composite business-insurance." 612 F.2d, at 817. Citing only the District Court opinion in *Pireno* which was later to be reversed by the Second Circuit and without giving any consideration either to whether the peer review system was "regulated by state law," or to the "critical determinant in identifying insurance" of whether the conduct involved "the underwriting or spreading of risk," *Group Life & Health Ins. Co. v. Royal Drug Co., supra,* 440 U.S. at 213, the *Bartholomew* majority nonetheless held that the elements of the McCarran-Ferguson exemption had been satisfied. Unless this Court is prepared to overrule *Royal Drug* barely three years after it was decided, the conflict in the circuits must be resolved by affirming *Pireno* which was faithful to this Court's decisions and by disapproving *Bartholomew* which either disregarded or misinterpreted those decisions.

Nothing said by petitioners or the *amici* supporting them justifies departing from this Court's holding in *Royal Drug*. Petitioners and *amici* all argue that the peer review system involves the "interpretation and enforcement" of an insurance policy as this Court used that phrase in *National Securities,* 393 U.S., at 460, and that this fact alone is sufficient to bring the peer review system within the McCarran-Ferguson exemption, but this argument misses the mark. Even if the peer review involves the "interpretation

and enforcement" of a policy that alone is not enough to satisfy the requirements of the McCarran-Ferguson Act. As this Court held in *Royal Drug*, the activities must also involve "the underwriting or spreading of risk." 440 U.S., at 213. *Variable Annuity*, for example, involved the "interpretation and enforcement" of the policy between the insurer and the insured and even involved an actuarial calculation of the insured's benefits but this Court nonetheless held the exemption inapplicable because the agreements involved no "investment risk-taking on the part of the company." 359 U.S., at 71. Here, as in *Royal Drug*, the peer review system is at most a cost-containment mechanism. Peer review is not an actuarial "underwriting or spreading of risks," *Group Life & Health Ins. Co. v. Royal Drug Co., supra*, 440 U.S., at 213, nor does it involve any "investment risk-taking on the part of the company," *Securities and Exchange Commission v. Variable Annuity Life Ins. Co., supra*, 359 U.S., at 71, and is therefore outside the scope of the McCarran-Ferguson exemption even if it involves the "interpretation and enforcement" of the policy.

Petitioners' argument is misplaced for another reason. Even if peer review involves the "interpretation and enforcement" of a policy, that does not mean that respondent's complaint is exempt from antitrust scrutiny. Respondent's antitrust challenge is not directed to the insurance policies issued by Union Labor or even at the "interpretation and enforcement" of those policies. Rather, respondent's complaint is to the separate agreement between Union Labor and NYSCA formally establishing the peer review system. The agreement between Union Labor and NYSCA exists wholly apart from the agreements Union Labor has with its policyholders. Like the pharmacy agreements in *Royal Drug*, the agreement between Union Labor and NYSCA is "not 'between insurer and insured' [but is instead a] separate contractual arrangement between [the insurer] and [an association of providers] engaged in the

sale and distribution of goods and services other than insurance." 440 U.S., at 216. As such, it is like any other mechanism an insurer might use to satisfy its contractual obligations to its policyholders, but is not the "business of insurance" within the meaning of the McCarran-Ferguson Act.

B. Any "Business of Insurance" Exemption Is Lost When an Insurer Combines with an Entity that is Not Within the McCarran-Ferguson Exemption

Even if the reimbursement scheme involved here could be construed to be the "business of insurance" when performed solely by an insurance company, the exemption should not apply here because the peer review system is the product of concerted action between an insurer and an association of providers. In *Royal Drug*, this Court followed a long line of cases holding that exemptions from the antitrust laws are lost when an exempt entity acts in concert with nonexempt parties.[13] Because the agreements in *Royal Drug* were between the insurer and providers, there was an entirely independent amd alternative basis why the McCarran-Ferguson exemption did not apply:

> Application of this principle is particularly appropriate in this case because the Pharmacy Agreements involve parties wholly outside the insurance industry. In analogous contexts, the Court has held that an exempt entity forfeits antitrust exemption by acting in concert with nonexempt parties. . . .

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[13] 440 U.S., at 231-33, *citing Case-Swayne Co. v. Sunkist Growers, Inc.*, 389 U.S. 384 (1967) and *United States v. Borden Co.*, 308 U.S. 188 (1939) (loss of exemption under Capper-Volstead Act); *Ramsey v. United Mine Workers*, 401 U.S. 302 (1971), and *United Mine Workers v. Pennington*, 381 U.S. 657 (1965) (loss by a union of exemption because of agreement with one set of employers to impose wage scale on other bargaining units).

> If agreements between an insurer and retail pharmacists are the "business of insurance" because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control — whether with automobile repair shops or landlords. Such agreements would be exempt from the antitrust laws if Congress had extended the coverage of the McCarran-Ferguson Act to the "business of insurance companies." But that is precisely what Congress did not do.

440 U.S., at 231-33 (footnotes omitted). In a footnote, the Court elaborated:

> There is no principled basis upon which a line could rationally be drawn that would extend the McCarran-Ferguson Act exemption only to an insurer's agreement with providers of goods and services to be furnished to its policyholders — such as agreements with hospitals, doctors, lawyers, and the like. But assuming that such a line could rationally be drawn, to hold that even such provider agreements are the "business of insurance" is to ignore the language and purpose of the Act not to exempt the insurance industry as such from the antitrust laws.
>
> Moreover, exempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Recent studies have concluded that physicians and other health-care providers typically dominate the boards of directors of Blue Shield plans. Thus, there is little incentive on the part of Blue Shield to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation of health-care costs to the detriment of consumers generally.

Id., at 232 n.40. The Second Circuit in *Pireno* cited and relied upon this analysis in holding petitioners' activities to be beyond the scope of the exemption. 650 F.2d, at 392.

Accord, Liberty Glass Co. v. Allstate Ins. Co., 607 F.2d 135 (5th Cir. 1979). In *Bartholomew*, by contrast, the Fourth Circuit did not even consider this alternative basis of the *Royal Drug* holding nor — quite obviously — did it follow it. Petitioners and their supporting *amici* follow the approach of *Bartholomew* and completely ignore this alternative basis for the holding in *Royal Drug*. *Royal Drug* correctly applied established antitrust precedents in reaching its decision and no reason whatsoever has been mentioned for reaching a different conclusion now.

II. THE McCARRAN-FERGUSON EXEMPTION IS NOT APPLICABLE BECAUSE PETITIONERS' CONDUCT IS NEITHER COMPELLED NOR ACTIVELY SUPERVISED BY THE STATE OF NEW YORK

Even if petitioners' conduct were considered to be the "business of insurance," the exemption would only apply "to the extent that such business is . . . regulated by state law." 15 U.S.C. § 1012(b). The argument of petitioners and *amici* that New York's general scheme of insurance regulation constitutes a sufficient degree of regulation to provide an exemption under the McCarran-Ferguson Act[14] flies in the face of the express intent of the authors of the Act and a long line of the decisions by this Court.

In allowing an antitrust exemption for conduct "regulated by State law," Congress intended to adopt and follow the standards articulated in *Parker v. Brown*, 317 U.S. 341 (1943). Under *Parker* and its progeny, "state action" only provides an antitrust defense for conduct that is specifically compelled by the State acting in its sovereign capacity and actively supervised by the State. *E.g., California Retail*

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[14]ULL Br. at 31-34; AIA Br. at 23-28; NAIC Br. at 16-23.

Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980); *New Motor Vehicle Board v. Orrin W. Fox Co.*, 439 U.S. 96 (1978); *Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). The State of New York concededly has no statute or administrative regulation which requires petitioners' peer review system nor is it suggested that the State of New York actively supervises that conduct. Since petitioners' actions are "not regulated by state law" within the meaning of *Parker*, the McCarran-Ferguson Act requires that the Sherman Act be applied.

A. Congress Intended that this Court's Decision in *Parker v. Brown* Be the Standard for Measuring the Extent of State Regulation in Section 2(b)

Parker v. Brown and *United States v. South-Eastern Underwriters Association* both involved important issues concerning the respective roles of the State and Federal governments in our federal system. Both cases were before this Court at approximately the same time and Congress had the benefit of this Court's decision in *Parker* while it was considering the legislation eventually enacted as the McCarran-Ferguson Act. *Parker v. Brown* was mentioned prominently and repeatedly in the congressional debates and the proponents of the legislation clearly intended that *Parker v. Brown* define the state regulation clause in section 2(b). *See generally* Weller, *supra*, 1978 Duke L.J., at 615-19.

Parker was decided by this Court while Congress was considering the industry-sponsored Walter-Hancock bills which would have provided a total antitrust exemption for the insurance industry. The Roosevelt Administration opposed the total exemption approach arguing that *Parker v. Brown* struck the appropriate balance between state regulation and the federal antitrust laws. *See, e.g., Joint Hear-*

ings on S. 1362, H.R. 3269 and H.R. 3270 Before the Subcomms. of the Comms. on the Judiciary, 78th Cong., 1st and 2d Sess., pt. 1, at 49, 52-53 (1943) (Attorney General Biddle). The Committee Reports on the Walter-Hancock bills rejected this argument, however, because they read *Parker v. Brown* as depending upon an affirmative statement of federal policy authorizing the state regulatory scheme: "*Parker v. Brown* dealt with a State commission authorized by State statute to enforce a program in conformity with, if not supplementary to, a federal statute. Obviously, all State regulation concerning insurance does not and would not fall in such a category."[15]

The industry-sponsored Walter-Hancock bills were rejected by Congress and the National Association of Insurance Commissioners came forward with a substitute bill which eventually became the McCarran-Ferguson Act. The NAIC explained the antitrust exemption in its proposed bill as being based on *Parker v. Brown*: "This subsection . . . is intended, among other things, to remove any doubt as to the validity of State regulation of insurance rates, and is based in a general way, upon the decision of the United States Su-

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[15]H.R. Rep. No. 873, 78th Cong., 1st Sess. 7 (1943); S. Rep. No. 1112, 78th Cong., 2d Sess. 5 (1944). In reaching this conclusion, the Committees accurately anticipated the result reached more than three decades later in *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980), where this Court held that California's liquor pricing statutes were unconstitutional under the Supremacy Clause because they conflicted with the Sherman Act. By its expression of the policy "that the continued regulation and taxation by the several States of the business of insurance is in the public interest" and by its mandate that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance," Congress exempted State insurance regulatory statutes from the sort of Supremacy Clause constitutional challenge seen in *Midcal Aluminum*.

preme Court in the case of *Parker v. Brown* . . . ."[16] President Roosevelt's letter to Senator Radcliffe likewise explained the insurance industry's antitrust exemption in terms drawn from *Parker v. Brown:*

> [T]here is no conflict between the application of the antitrust laws and effective State regulation of insurance companies, and there is no valid reason for giving any special exemption from the antitrust laws to the business of insurance. The antitrust laws prohibit private rate fixing arrangements between insurance companies and acts of boycott, coercion, or intimidation. The antitrust laws do not conflict with affirmative regulation of insurance by the States such as agreed insurance rates if they are affirmatively approved by State officials.

13 Public Papers and Addresses of Franklin D. Roosevelt: 1944-45, at 587 (Rosenman ed. 1950), *reprinted in* 91 Cong. Rec. 482 (1945).

In the congressional debates on the McCarran-Ferguson Act, there emerged two different approaches to the antitrust exemption in section 2(b). *See St. Paul Fire & Marine Ins. Co. v. Barry, supra,* 438 U.S., at 547 n.20; *Federal Trade Commission v. Travelers Health Association,* 362 U.S. 293, 299-302 (1960). Senator Taft argued for the primacy of federal antitrust laws over state insurance regulation saying, "We wish [the states] to put their houses in order by adopting laws which do not conflict with the Sher-

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[16]NAIC Memorandum of Explanation, *reprinted in* 90 Cong. Rec. A4407 (1944). The form of antitrust exemption included in the original NAIC bill was not enacted by Congress. In a later monograph considering the antitrust exemption which was actually included in the McCarran-Ferguson Act, however, the NAIC wrote, "Section 2(b) is essentially an enunciation of the *Parker v. Brown* decision." National Association of Insurance Commissioners, *Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business* at 27 n.58 (1974).

man Act." 91 Cong. Rec. 484 (1945). As a result, Senator Ferguson offered an amendment which was accepted by the Senate which would have denied any antitrust exemption: "No act [of Congress], except ... the Sherman Act and ... the Clayton Act, shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance ...." *Id.*, at 486. Although approved in the Senate, the Ferguson amendment was rejected by the House which had consistently taken a more lenient view of the scope of the antitrust exemption and the differences went to a Conference Committee for resolution. *Id.*, at 1208.

The present language of section 2(b) emerged from the Conference Committee, *id.*, at 1396, and was accepted by the House without further debate. *Ibid.* When the Conference Committee Report was considered in the Senate, however, the conferees were explicit that affirmative state regulation was required to satisfy the limited antitrust exemption in section 2(b). Senator Murdock, for example, said:

> I agree thoroughly with the Senator from Maine [Senator White] that insofar as the States step into the picture affirmatively and act by regulation, they may do so. As the Senator from Wyoming [Senator O'Mahoney] has said, we convey no authority, we simply recognize their right to regulate. Insofar as they fail to cover the same ground covered by the Sherman Act and the Clayton Act, those acts become effective again.

91 Cong. Rec. 1444 (1945). Senator O'Mahoney, one of the Senate conferees, expressed the same view:

> Mr. President, there are three forms of regulation. There is State regulation.... There is Federal regulation as a legal possibility, but no one is urging it now.
>
> The third, and this has been harmful to the public interest, is regulation by private combination and groups; a type of regulation which has been enforced by private combinations and groups

> through private rules and regulations under which persons engaged in the insurance industry could be tried and convicted for the violation of private law. That type of regulation would be absolutely outlawed should the conference report be adopted.

Id., at 1483. Indeed, Senator O'Mahoney specifically explained section 2(b) as embodying the standards of this Court's *Parker v. Brown* decision:

> I take it that the Senator is apprehensive lest a statute passed by a State attempting to give validity to a private agreement to regulate would be recognized under [the proviso clause]. I think it would not, because . . . [in] Parker against Brown, I find this language from the Supreme Court:
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> "True, a State does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful."
>
> Therefore I have no doubt in my own mind that no State, under the terms of the conference report, could give authority to violate the Sherman antitrust law. But we have this field in which definitions may be a little bit difficult and vague.

91 Cong. Rec. 1480 (1945). In signing the McCarran-Ferguson Act, President Roosevelt expressed a similar view on the interplay of state regulation and federal antitrust laws: "It is clear from the legislative history and the language of this Act, that the Congress intended no grant of immunity for monopoly or for boycott, coercion or intimidation. Congress did not intend to permit private rate-fixing, which the antitrust act forbids, but was willing to permit actual regulation of rates by affirmative action of the states." 13 Public Papers and Addresses of Franklin D. Roosevelt: 1944-45, at 587 (Rosenman ed. 1950).

In an article written after the statute was enacted, Senator McCarran explained section 2(b) as requiring the same sort of affirmative expression of State policy that has

distinguished cases such as *Parker v. Brown* and *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977), from other cases such as *Goldfarb v. Virginia State Bar* and *Cantor v. Detroit Edison Co.*:

> State regulation in such a field, to constitute an effective assertion of jurisdiction, probably would have to meet certain minimum standards. The State law should be explicit with respect to the practice which it is sought to regulate. Probably also the State law should be prohibitory rather than permissive. That is, it should prohibit the particular practice except in accordance with specified procedure and subject to State approval, rather than simply in terms permitting the practice in question.

McCarran, *Federal Control of Insurance: Moratorium Under Public Law 15 Expired July 1*, 34 A.B.A.J. 539, 542 (1948). Senator McCarran went on to explain the required degree of active State regulation in terms that are suggestive of the distinctions made by this Court in cases such as *Orrin W. Fox* and *Midcal Aluminum*:

> Machinery should be provided for regulating the practice, and the law should designate an authority, in either some official or some agency of the State, to exercise the State regulatory power. It should lay down general standards to govern the discretion to be exercised by such authority. Probably it should also include provisions for public notice, and an opportunity for hearing, in advance of the exercise of such discretionary authority; and there should be some provision for appeal from the decisions made by such authority.

Ibid.

While this Court has not yet considered the precise question whether section 2(b) embodies the standards of

Parker v. Brown,[17] language in this Court's opinions suggests tht the rule of *Parker* is to be applied. In *National Securities*, for example, this Court held that State approval of the merger between the two insurance companies was not compelled by the State of Arizona: "Arizona has not commanded something which the federal government seeks to prohibit. It has permitted [the insurance companies] to consummate the merger; it did not order them to do so." 393 U.S., at 463. Similiarly, in *Barry* this Court analyzed the legislative history of section 2(b), 438 U.S., at 546-50, and concluded that the standard under section 2(b) was whether the "insurance practices . . . are compelled or specifically authorized by state regulatory policy," 438 U.S., at 555, which is, of course, the standard that has developed under *Parker v. Brown* and its progeny. *See also Securities and Exchange Commission v. National Securities, Inc., supra; Federal Trade Commission v. National Casualty Co.*, 357 U.S. 560 (1958).

The question of the standard to be applied under section 2(b) is squarely before this Court and this Court should answer that question by applying the body of decisions that has been developed under *Parker v. Brown*.

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[17]It appears that only one lower court decision has considered whether Congress intended to follow the standards of *Parker v. Brown* in section 2(b). In *Allstate Ins. Co. v. Lanier*, 242 F. Supp. 73, 87 (E.D.N.C. 1965), *aff'd* 361 F.2s 870 (4th Cir.), *cert. denied*, 385 U.S. 930 (1966), the court stated:

"What is of the utmost significance is that this decision of *Parker v. Brown* was considered at the time the McCarran Act was being considered and was specifically referred to on numerous occasions. Section 2(b) was written into the Act as an enunciation of the *Parker v. Brown* decision."

B. Petitioners' Peer Review Process Does Not Qualify for the "State Action" Exemption of *Parker v. Brown* and Its Progeny

Once it is decided that *Parker v. Brown* defines the State regulation clause in section 2(b), it is undeniable that petitioners are not entitled to the McCarran-Ferguson exemption because the State of New York's regulatory involvement falls far short of what is necessary to satisfy *Parker*. In *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980), this Court recently considered the elements of the "state action" defense originally set forth in *Parker v. Brown* and followed in subsequent cases. *E.g., New Motor Vehicle Board of v. Orrin W. Fox Co., supra; Cantor v. Detroit Edison Co., supra; Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). In *Midcal*, this Court recognized that the "state action" exemption begins with the question whether the anticompetitive conduct was compelled by the State acting in its sovereign capacity. After all, if the anticompetitive conduct was not mandated by the State, it would by definition be private conduct not entitled to the mantle of the "state action" exemption. Only after it had been decided that the State statute requires conduct inconsistent with the Sherman Act does it become appropriate to consider whether the other criteria for the "state action" exemption have been satisfied. The *Midcal* Court described these two additional criteria:

> These decisions establish two standards for antitrust immunity under *Parker v. Brown*. First, the challenged restraint must be 'one clearly articulated and affirmately expressed as state policy'; second, the policy must be 'actively supervised' by the State itself.

445 U.S., at 105. In *Midcal*, the State law required wine producers and wholesalers to enter into fair trade agreements with retailers or to post binding resale price sched-

ules. The system thus met the first test of being affirmatively required by the State, but did not meet the second because the State did not review the reasonableness of the prices, monitor market conditions, or engage in any "pointed reexamination" of the program. *Id.*, at 105-06. This Court held, "[T]he national policy in favor of competition cannot be thwarted by casting such a gauzy cloak on state involvement over what is essentially a private price-fixing arrangement." *Id.*, at 106.

Accordingly, in those cases where a State statute mandated conduct inconsistent with the Sherman Act and was supported by an affirmative expression of state policy and was actively supervised by the state, the "state action" exemption has been upheld. *E.g., Bates v. State Bar of Arizona, supra.* And, in those cases where the State statute did not require (though it may have permitted) conduct violative of the Sherman Act, the Court has held that any anticompetitive effects were solely the result of private conduct and not "state action." *E.g., Cantor v. Detroit Edison Co., supra; Goldfarb v. Virginia State Bar, supra.*

Petitioners' peer review system is precisely the "type of regulation . . . by private combinations and groups through private rules and regulations," 91 Cong. Rec. 1483 (1945), that was condemned by congressional proponents of the McCarran-Ferguson Act and it should not qualify for the limited exemption in section 2(b). The State of New York's regulatory involvement in petitioners' scheme is minimal at best. New York requires insurance companies to submit health and accident policies to the Superintendent of Insurance for approval. New York Insurance Law § 255d (McKinney 1966). It also prohibits insurers from engaging in unfair claims settlement practices. New York Insurance Law § 40-d (McKinney Supp. 1981-82). No where, however, does the State of New York require insurers to engage in a peer review process, *cf. Cantor v. Detroit Edison Co., supra,* nor does the State actively supervise the prices set through

this process. *Cf. California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., supra.*

Quite simply, the *Parker* and *Midcal* tests are not met. The restraint is not "clearly articulated and affirmatively expressed in state policy" nor is it "actively supervised" by the State. Petitioners are not entitled to the exemption from the antitrust laws afforded by section 2(b).

III. PETITIONERS' PEER REVIEW SYSTEM IS A GROUP EFFORT TO DENY RESPONDENT MONETARY BENEFITS AND IS THEREFORE A "BOYCOTT" AS DEFINED BY THIS COURT IN *BARRY*

In its simplest and most basic terms, petitioners' peer review system is a group effort by an insured and an association of providers to deny respondent monetary benefits. *See* notes 7 and 8, *supra*. It is therefore a "boycott" as this Court defined that term in *St. Paul Fire & Marine Ins. Co. v. Barry* and under section 3(b) is not entitled to the antitrust exemption even if the peer review system otherwise qualifies as "the business of insurance" and is "regulated by state law." Whether petitioners' conduct is a "boycott" within the meaning of section 3(b) is, of course, a much different question than whether it is an unlawful boycott under antitrust laws. The legality of that conduct is not now before this Court for consideration.

In *Barry* this Court said, "The generic concept of boycott refers to a method of pressuring a party with whom one has a dispute by withholding, or enlisting others to withhold, patronage or services from the target." 438 U.S., at 541. Here, NYSCA is enlisting Union Labor and its insureds to withhold patronage from respondent Pireno. In *Barry* the Court addressed this type of arrangement: "The enlistment of third parties in an agreement not to trade, as a means of compelling capitulation by the boycotted group,

long has been viewed as conduct supporting a finding of unlawful boycott." *Id.*, at 544-45.

It matters not that Union Labor, acting alone, could have decided whether to deal with respondent Pireno, and, if so, on what terms. The law has always recognized the freedom of a single trader unilaterally to refuse to deal with another and it is the concerted refusal to deal which is the essence of the concept of "boycott." *See St. Paul Fire & Marine Ins. Co. v. Barry, supra*, 438 U.S., at 541-44. Even in the health care sector, a third-party payor acting alone can decide with whom it will deal without its decision being a "boycott" or even an antitrust violation. *See Manasen v. California Dental Service*, 1981-1 CCH Trade Cas. ¶ 63,959 (N.D. Cal. 1980); *Pharmacist Political Action Committee v. Harris*, 1980-81 CCH Trade Cas. ¶ 63,866 (D.Md. 1980); *Blue Cross and Blue Shield v. Michigan Association of Psychotherapy Clinics*, 1980-2 CCH Trade Cas. ¶ 63,351 (E.D. Mich. 1980). It is the combination or group action to deny respondent monetary benefits which constitutes the "boycott" within the meaning of section 3(b) and which takes petitioners' agreement outside of the McCarran-Ferguson exemption.

CONCLUSION

The judgment of the United States Court of Appeals for the Second Circuit should be affirmed.

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Amicus Brief

4

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Nos. 81-389 and 81-390

IN THE

Supreme Court of the United States

October Term, 1981

No. 81-389

UNION LABOR LIFE INSURANCE COMPANY,
Petitioner,

versus

A. ALEXANDER PIRENO,
Respondent

No. 81-390

NEW YORK STATE CHIROPRACTIC ASSOCIATION,
Petitioner,

versus

A. ALEXANDER PIRENO,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC. IN SUPPORT OF RESPONDENT, A. ALEXANDER PIRENO

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ISSUE PRESENTED

Whether an insurer's arrangement to utilize a claims "peer review" committee to determine the level of reimbursement for the insurer's policyholders or subscribers for health care services rendered by chiropractors is an arrangement which is the "business of insurance" so as to be exempt from the antitrust laws under §2(b) of the McCarran-Ferguson Act, 15 U.S.C. §1012(b).

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A. ALEXANDER PIRENO,
Respondent

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC. IN SUPPORT OF RESPONDENT, A. ALEXANDER PIRENO

INTEREST OF *AMICUS CURIAE*

Pursuant to Rule 36 of the Rules of this Court and with the consent of all parties,[1] the Association of

[1]Letters of Consent have been filed with the Clerk.

American Physicians & Surgeons, Inc. (AAPS) respectfully files this brief *amicus curiae* in support of the Respondent, A. Alexander Pireno.

AAPS is a voluntary association formed in 1943 by private, practicing physicians and surgeons. AAPS is incorporated under and by virtue of the laws of the State of Indiana, and has its principle office located in Burke, Virginia. AAPS is the largest association with nationwide membership in the United States devoted exclusively to representing the private, practicing physician and surgeon. AAPS has members in every state and territory in the United States, and in the District of Columbia.

Review of insurance claims in medicine parallels precisely the review mechanism found in this case. Accordingly, the decision will have far-reaching consequences for the practice of medicine. The members of AAPS strongly support, endorse and routinely participate in peer review in hospitals wherein they enjoy medical staff privileges, and in medical societies and specialty societies where peer review is conducted for purposes of the education of the members of the profession, but they do not support or endorse the so-called "peer review" for purposes of determining the levels of payment of insurance claims. Experience has taught the members of AAPS that such "peer review" is not true peer review at all, but, rather, a means by which fees are arbitrarily fixed by the physicians' and surgeons' fellow practitioners. The members of AAPS strongly believe that the claims "review" which is the subject of this case is a vehicle whereby prices are fixed

arbitrarily, and where certain members of the medical profession are subjected to combinations of fellow practitioner-competitors and insurance companies who and which, together, can, with impunity, force another practitioner from competition.

The members of the Association of American Physicians & Surgeons, Inc., as private, practicing physicians and surgeons, have faced in the past, and continue to face, review by "peer review" committees in order to determine the levels of payment of insurance claims. AAPS, accordingly, has called upon the collective experience of its membership with claims "peer review" to illustrate to the Court in this brief *amicus curiae* the nature of claims "peer review" in medicine. Hopefully, what is presented herein will assist the Court by providing the factual setting in which such contested review is conducted in medicine. In determining whether claims "peer review" is or is not part of the "business of insurance" within the meaning of §2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), the facts surrounding claims "peer review" are fundamental. It is important to present some facts showing the extent to which such "peer review" is conducted in all segments of health care and on all associational levels in the United States to illustrate the magnitude of the American health care dollar affected by such claims "peer review".

For all the foregoing reasons and purposes AAPS files the within brief *amicus curiae* in support of the Respondent, A. Alexander Pireno,

SUMMARY OF ARGUMENT

The issue in this case is whether the "business of insurance" under §2(b) of the McCarran-Ferguson Act, 15 U.S.C. §1012(b), includes a practice used by health insurance companies to determine whether to pay health insurance claims under their policies. Insurance companies often rely upon the "recommendations" of "peer review" committees composed of professionals who are appointed by their state or county medical associations and societies for purposes of determining whether or not to pay a claim, or, the level of payment.

The "peer review" mechanism is a patently unfair and arbitrary method of determining the level of claims payment. The claims "peer review" process is completely open to abuse, and, by its very nature, serves as a vehicle whereby a few members of the medical community may combine together and set the level of fees of fellow practitioners, and, potentially, control the availability of providers.

As the facts presented herein must clearly indicate, the process of claims "peer review" cannot be regarded as the "business of insurance" within the meaning of §2(b) of the McCarran-Ferguson Act, 15 U.S.C. §1012(b), as defined in the landmark decisions in *Group Life & Health Ins.* v. *Royal Drug Co.*, 440 U. S. 205 (1979) and *SEC* v. *National Securities, Inc.*, 393 U. S. 453 (1969). Those decisions were reaffirmed in the decision of the Second Circuit below.

First of all claims "peer review", by its very nature, is anticompetitive. It is neither a thorough nor thoughtful form of retrospective review. Under "arrangements" between insurers and medical societies and associations, committees of a physician's or surgeon's fellow practitioners and competitors, who may or may not practice in the same specialty or region, "recommend" to insurance carriers the level of the physician's or surgeon's fees. No records are kept by these committees; no procedural protections are afforded; no standard fees are "discussed"; and no evidence is introduced. The committees simply "recommend" a fee. If the "recommendation" is of a smaller amount than claimed, the insurance carrier accepts it.

Such "review" parallels the Pharmacy Agreements in *Group Life & Health Ins.* v. *Royal Drug Co.*, 440 U. S. 205 (1979) in that the insurer, here, is only concerned about "reimbursement", not "underwriting" or "risk-spreading." Claims "peer review" is not provided for in any contract of insurance. The insured plays no role in it, and does not agree to it for it is not mentioned in the policy. It is thus a mechanism wholly unrelated to the insurer-insured relationship. Claims "peer review" is not regulated by any state laws. Whereas claims "peer review" might be a good way, if not a silent one, for insurers to limit costs, it is not the "business of insurance" as contemplated in §2(b) of the McCarran-Ferguson Act, 15 U.S.C. §1012(b).

ARGUMENT

I

CLAIMS "PEER REVIEW" IS A PRACTICE OF FEE REVIEW WHICH IS ARBITRARY, UNFAIR AND, BY ITS VERY NATURE, ANTICOMPETITIVE

Claims "peer review" is a mechanism whereby an insurance company has claims reviewed by a committee of professionals for purposes of determining whether the company will pay the claim or another level of payment. The process provides no procedural fairness or orderly manner of review.

Generally, in medicine, claims "peer review" committees are formed by the state medical associations and the county medical societies. For the most part, such committees are called "claims and utilization review committees." As a general rule, constitutions and bylaws of the various state medical associations and county medical societies do not speak to either the formation of such committees or the functions of them. Though not in every instance, certainly in many instances, "claims and utilization review committees" are composed of members of the medical association or medical society appointed each year by the president thereof without regard to any constitutional or bylaw provision creating the committee.

In nearly every instance these "claims and utilization review committees" have no rules or standards by which they are guided in deciding cases. The physician or surgeon whose claims are subject to a committee's

review is afforded no protections once he is called to appear.

The insurance company which utilizes these committees usually has an agreement with the state or county medical association or society whereby it will forward to the medical association or medical society a stipulated sum of money—maybe $25 or $30—for each case to cover the committee's "expenses" for the "review." With the sum of money for "expenses," the insurance company customarily forwards a letter, accompanied by a copy of the physician's or surgeon's statement upon which the claim is based, to the "review" committee requesting its recommendation relative to whether the insurance company should pay the claim. The patient is usually not notified of any such "review." The physician or surgeon whose claim is to be "reviewed" is notified by letter from the chairman of the "claims and utilization review committee" of the pending "review" of his fees charged in the claim, and is requested to attend a scheduled meeting of the committee.

At the committee meeting the insurance company may send its representative.[2] When the subject physician or surgeon enters the conference room where the committee meets he is faced by between ten (10) and twenty (20) of his fellow physicians and/or surgeons, and maybe, the insurance company representative.

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[2]In some medical "peer review" meetings the insurance company may send its representative. There exists no pattern. In most instances where the carrier's representative is present, he seldom participates in any discussion.

From that moment forward, the process has no order. The physician or surgeon whose claim is the subject of the "review" is subjected to wide-ranging and often embarrassing questioning. No "standard" fees are discussed.[3] The committee members may *not even have among their membership* a physician or surgeon of the specialty of the subject physician or surgeon, or a member from the region of the state where the subject physician or surgeon practices. In almost every instance there is nothing more to guide the "claims and utilization review committee" than the subject physician's or surgeon's statement. Diagnosis, history of the patient, prognosis of the malady, and treatment are treated summarily. The peculiar circumstances of each individual patient whose diagnosis and treatment is discussed seems, in most claims "peer review" settings, to be less than relevant. The patient is not present. No written findings of fact are prepared.

In the end, after an unstructured and sometimes rambling and accusatorial, committee-weighted "dialogue," the meeting concludes. If the decision is not announced immediately—and it seldom is—the subject physician or surgeon receives a letter from the committee wherein it announces that it has made a "recommendation" to the insurance carrier. In most in-

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[3]Whether standard fees are actually used to make a recommendation is the subject of wide-ranging speculation. Often fee levels paid to "participating" physicians and/or surgeons in plans such as those promoted by Blue Cross Blue Shield are said to be used as a guideline in a Blue Cross Blue Shield claim. Other insurance companies may have their own "suggested" fee levels.

stances, the committee recommends a reduced fee. That recommendation for a reduction in fees is followed by the insurance company. It, in turn, writes to its insured or subscriber that, based upon the claims committee's recommendation, the claim either will not be paid at all or a reduced amount will be paid.

As a matter of fact, recommendations from claims "peer review" committees of non-payment or a reduction in payment are, for the most part, always followed by the insurance companies. To refer to those decisions as "recommendations" somewhat misses the point.

Throughout the "review" process no transcript of evidence is maintained; no minutes are taken; and no rules are followed. The committee hears no "evidence" in the formal sense. The physician or surgeon is never apprised of any standards or norms which determine the level of fees. The committee may not have one of its membership from the specialty under discussion, or from the region of the state where the subject physician or surgeon practices. The committee, as a general rule, has no more information before it than the physician's or surgeon's statement upon which the insurance claim is based. No findings of fact are prepared.

At the conclusion of the meeting, the physician and/or surgeon members of the claims "peer review" committee determine, for all practical purposes, the fee amount which a fellow physician's or surgeon's patient will be reimbursed.

The foregoing description of the claims "review" process is a generalized one to be sure. It may or may not describe what actually occurred in the instant case. It does present, however, in general terms, the process of claims "peer review" as found in medicine. The claims "peer review" process in medicine parallels those found in the chiropractic, podiatric, dental and optometric fields.

When one totals the thousands of "reviews" being conducted each month by county and state medical societies and associations and chiropractic, dental, podiatric, and optometric associations for insurance companies, it is readily acknowledged that a significant portion of the health care dollar spent in the United States is being affected by this claims "review" process.

Of concern to the members of the AAPS is the anti-competitive nature of claims "peer review" and the fact that it has been and is the subject of abuse. Certain physicians and/or surgeons may be singled out or "red-flagged" for frequent review. Importantly, with large insurance programs which invite physician and surgeon "participation," such as the Blue Cross Blue Shield plans, the "peer review" of insurance claims provides a means of forcing physicians to "participate," or suffer frequent "review." The directorships of the Blue Cross Blue Shield companies and the very committees performing claims review may even have one or more of the same physician and/or surgeon members. Review may also be prompted by the mem-

bers of the state or county associations or societies themselves for a variety of anticompetitive reasons.

No state in the union has ever sought to regulate, by the legislation or otherwise, the claims "peer review" process. Instead, claims "peer review" is entirely self-regulated. The course of conduct of each committee is determined by the committee upon each claim reviewed or by the society or association of which it is a part.

Insurance claims "peer review" is not the same peer review which is conducted for the edification of the members of the profession. Claims "peer review" does not focus on the quality of care. Unlike in-hospital peer review, claims "peer review" is not the retrospective examination of the clinical application of medical knowledge. Instead, it is an unstructured, arbitrary and nonrational method of allowing a physician's or surgeon's competitors to set the level of his fees without regard to any previously-announced standards, norms or criteria.

II

CLAIMS "PEER REVIEW" IS NOT THE "BUSINESS OF INSURANCE" WITHIN THE MEANING OF §2(b) OF THE McCARRAN-FERGUSON ACT.

A. Claims "Peer Review" Is Not a Form of Risk-Spreading.

This Court in *Group Life & Health Ins.* v. *Royal Drug Co.*, 440 U. S. 205 (1979) defined the basic premise in the definition of the "business of insur-

ance" as found in §2(b) of the McCarran-Ferguson Act, 15 U.S.C. §1012(b). Wrote this Court, "The underwriting or spreading of risk is a critical determinant in identifying insurance." *Id.* at 213.

As set forth in *Royal Drug,* the purpose behind the enactment of §2(b) of the McCarran-Ferguson Act was not to provide a total exemption from the antitrust laws for the insurance industry, but a specific exemption for "activities of insurance companies [which] are the business of insurance and regulated by state law." *Id.* at 219. "To the extent that such [insurance] business is not regulated by state law" the antitrust laws would clearly apply.[4]

Accordingly, the "business of insurance" as found in §2(b) of the McCarran-Ferguson Act, 15 U.S.C. §1012(b), was intended by Congress to have a very narrow and restrictive meaning.

The Court below stated unequivocally that "[p]eer review is plainly not a form of risk-spreading." *Pireno* v. *New York State Chiropractic Ass'n.,* 650 F. 2d 387, 393 (2d Cir., 1981). The Court below examined the term "business of insurance," defining it as a mechanism which

> . . . disperses the risk of loss that will be suffered upon the occurrence of a particular event over a large number of policyholders, not all of whom will actually experience the event so that each policyholder can purchase protection against

[4] 91 *Cong. Rec.* 1443 (1945) (remarks of Sen. Ferguson); McCarran, "Federal Control of Insurance: Moratorium Under Public Law 15 Expired July 1," 34 *A.B.A.J.* 539, 540 (1948).

> the loss for a premium amount substantially smaller than the loss he would sustain if the event would occur to him. See 400 U. S. at 211, 99 S. Ct. at 1073, citing 1 G. Couch, Cyclopedia of Insurance Law §1:3 (2 ed. 1959). *See also* Note, *Supra,* 80 Colum. L. Rev. at 1478.

Id.

In *Royal Drug* this Court considered whether the Pharmacy Agreements of an insurer with three (3) pharmacies was the "business of insurance" for purposes of the McCarran-Ferguson Act exemption from the antitrust laws. Those Pharmacy Agreements, this Court stated, were not agreements "between insurer and insured."

Likewise, and importantly, those Pharmacy Agreements did not involve "underwriting" or "risk-spreading," the critical determinants in identifying insurance. *Group Life & Health Ins.* v. *Royal Drug Co.,* 440 U. S. 205, 214 (1979)

Where the Pharmacy Agreements may save the insurer money, and that savings *may* be passed on to the policyholder, such cannot be identified as part of the process of "underwriting" or "spreading the risk." Wrote this Court,

> The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The

> Agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."

Group Life & Health Ins. v. *Royal Drug Co.*, 440 U. S. 205, 214 (1979).

The claims "peer review" mechanism which is the subject of this action is not contractually provided for in insurance policies. Instead, it is the result of an arrangement between the insurer and the medical society or association. It may save the insurer money, and that savings *may* be passed on to policyholders, but it has no relationship with the process of "underwriting" or "spreading of risk." The mechanism is not a part of the insurance contract. The mechanism here, plays no role in "distribut[ing] the loss over as wide an area as possible." Cf. *German Alliance Ins. Co.* v. *Lewis*, 233 U. S. 389, 412 (1914).

Thus, under no interpretation of *Royal Drug* could claims "peer review" be considered "underwriting" or "risk-spreading" so as to constitute the "business of insurance." The "arrangements" in *Royal Drug* and here involve only reimbursement; nothing else.

B. Claims "Peer Review" Is Not Regulated by State Law.

Of significance here is that claims "peer review" is not the subject of legislation among the states. It, likewise, has never formed a part of the written contract

between insurer and insured. Instead, claims "peer review" is formed by an "agreement" between the insurance carrier and the state medical association and/or county medical society whereby insurance claims will be reviewed. Customarily, the "agreement" is nothing more than an oral "understanding." No state in the Union regulates claims "peer review" in health care. There exists no legislation in the states governing the conduct of these committees or the nature of these "understandings." Likewise, claims "peer review" is not the subject of any federal statute or regulation.

The words of §2(b) of the McCarran-Ferguson Act, 15 U.S.C. §1012(b), are clear. The Act reads, in pertinent part, that the federal antitrust laws ". . . shall be applicable to the business of insurance to the extent that such business is *not regulated by state law.*" (Emphasis added).

Claims "peer review" in health care is not the subject of state laws. The course of conduct of a "peer review" committee is determined by that committee or by the medical association or society of which it is a part.

Wrote this Court in *SEC* v. *National Securities, Inc.*, 393 U. S. 453, 459-460 (1969),

> Insurance companies may do many things which are subject to paramount federal regulations; only when they are engaged in the "business of insurance" does the [McCarran-Ferguson Act] apply. Certainly the fixing of rates is part of this

> business; that is what *South-Eastern Underwriters* was all about. The selling and advertising, *FTC* v. *National Casualty Co.*, 357 U. S. 560, 78 S. Ct. 1260, 2 L. Ed. 2d 1540 (1958), and the licensing of companies and their agents, cf. *Robertson* v. *People of State of California*, 328 U. S. 440, 66 S. Ct. 1160, 90 L. Ed. 1366 (1946), are also within the scope of the statute. Congress was concerned with the type of state regulation that centers around the contract of insurance, the transaction which *Paul* v. *Virginia* held was not "commerce." The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance."

Nothing in claims "peer review" is regulated by any state law or regulation covering those areas referred to as the "business of insurance." See *St. Paul Fire & Marine Ins. Co.* v. *Barry*, 438 U. S. 531, 539-540 (1978). §2(b) of the McCarran-Ferguson Act, 15 U.S.C. §1012(b), is clear and unequivocal. Claims "peer review" is not exempt from the federal antitrust laws.

C. Claims "Peer Review" Is Not a Part of the Insurer-Insured Contract.

Claims "peer review" owes its widespread use, not from the policies or contracts of insurance, but from the understandings or arrangements between insurance companies and state medical associations and county medical societies. Policyholders and subscribers—the consumers of health insurance—do not contractually

agree to the mechanism, for it is not a part of the insurance contract.

Referring to this Court's holding in *SEC* v. *National Securities, Inc.*, 393 U. S. 453, 460 (1969), the thrust of the meaning of the term "business of insurance" is clear, as the following indicates:

> . . . whatever the exact scope of the statutory term ["business of insurance"], it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

SEC v. *National Securities, Inc.*, 393 U. S. 453, 460 (1969)

The facts here lead directly to the significance of the holding of this Court in *Group Life & Health Ins.* v. *Royal Drug Co.*, 440 U. S. 205 (1979). In *Royal Drug* an insurance company had entered into "arrangements" for the purchase of goods and services from three (3) pharmacies, thereby enabling the insurer to minimize costs and maximize profits. Those "arrangements" affected the level of reimbursement. The insurer offered insurance policies which entitled the policyholders to obtain prescription drugs. If the pharmacy selected by the insured was a party to the insurer's "arrangement", known as the "Pharmacy Agreement", and was, thereby, a "participating" pharmacy, the insured was required to pay only $2 for every prescription drug. If the insured used a non-

participating pharmacy he was required to pay the full amount and be reimbursed for only 75% of the difference between the full price and $2. Stated this Court in *Group Life & Health Ins.* v. *Royal Drug Co.*, 440 U. S. 205, 209 (1979),

> The Pharmacy Agreements are not "between insurer and insured." They are separate contractual arrangements between Blue Shield and pharmacies engaged in the sale and distribution of goods and services other than insurance.

Though the insurer in *Royal Drug* argued that the Pharmacy Agreements closely affect the "reliability, interpretation, and enforcement" of the insurance contract and "relate so closely to their status as reliable insurers" as to fall within the exempted area, this Court failed to buy the contention. Instead, this Court wrote,

> At the most, the petitioners have demonstrated that the Pharmacy Agreements result in cost savings to Blue Shield which may be reflected in lower premiums if the cost savings are passed on to policyholders. But, in that sense, every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer. . . . If terms such as "reliability" and "status as a reliable insurer" were to be interpreted in the broad sense urged by the petitioners, almost every business decision of an insurance company could be included in the "business of insurance". Such a result would be plainly contrary to the statutory language, which

exempts the "business of insurance" and not the "business of insurers."

Group Life & Health Ins. v. *Royal Drug Co.*, 440 U. S. 205, 216-217 (1979).

The "arrangements" between insurance companies and societies for claims "peer review" are precisely the same as the "arrangements" referred to in *Royal Drug*. In fact, for some health insurers, claims "peer review" *forces* physician and surgeon "participation" in the same fashion as the Pharmacy Agreements. Neither, however, are contracts "between insurer and insured." Both involve only reimbursement, not "underwriting" or "risk-spreading."

III

PRACTICAL CONSIDERATIONS MUST WEIGH IN FAVOR OF THE RESPONDENT

Of grave concern to the AAPS is the threat that claims "peer review" presents to the economy at large. In this era of mandatory insurance, and, almost, over-insurance, the "business of insurers" pervades every phase of American life and endeavor. Were claims "peer review" to be exempted from the federal anti-trust laws all areas of the American economy would be subject to combinations of competitors setting the fees or prices for another under the blanket justification that it is the "business of insurance." It would be good business for insurance companies but a tyranny for the rest of the economy.

The health care industry is a multibillion dollar business. It is probably the largest single industry in the American economy. The process of claims "peer review" in health care alone affects a significant portion of the nation's commerce. An exemption from federal antitrust laws at the "reimbursement" end of the insurer's operation in health insurance could well cause every segment of the economy to suffer significant restraints, since the "reimbursement" end affects the prices, fees and costs of goods and services insured. Those goods and services are provided by *all* other segments of the economy.

As was true with *Royal Drug,* the outcome here is thus critical to the very purpose of the antitrust laws.

CONCLUSION

For the reasons set forth above, the *amicus curiae* urges that the decision of the United States Court of Appeals for the Second Circuit be affirmed.

Respectfully submitted,

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February, 1982

Amicus Brief

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

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Petitioner,

NEW YORK STATE CHIROPRACTIC ASSOCIATION,
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Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

AMICUS CURIAE BRIEF OF AUTOMOTIVE SERVICE COUNCILS, INC. IN SUPPORT OF RESPONDENT

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981
Nos. 81-389, 81-390

UNION LABOR LIFE INSURANCE COMPANY,
Petitioner,

NEW YORK STATE CHIROPRACTIC ASSOCIATION,
Petitioner,

v.

A. ALEXANDER PIRENO,
Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

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AMICUS CURIAE BRIEF OF AUTOMOTIVE SERVICE COUNCILS, INC. IN SUPPORT OF RESPONDENT

Automotive Service Councils, Inc. (ASC) is a national trade association, a federation of State incorporated councils which are comprised of automobile, truck and other vehicle repairers. ASC is a not-for-profit corporation chartered and headquartered in Illinois. Its 5,000 members are all small businesses, some incorporated, but most are individual proprietaries or partnerships. Approximately 2,500 ASC members are engaged in the repair of crash damaged vehicles involving sheet metal and structural restoration work in competition with each other and similar repair facilities of franchised automobile and truck dealers.

Pursuant to Rule 36 of the Rules of the Court and with the consent of all parties [1] ASC respectfully files this Brief Amicus Curiae in support of respondent A. Alexander Pireno.

INTEREST OF THIS AMICUS CURIAE

ASC members, as small business enterprises, function in an industry which is frequently manipulated and often dominated by powerful automobile casualty insurance corporations which control 90 percent of the cash flow to the collision repairmen. Their claims settlement procedures usually dictate the methods of repair, quality, total sums and terms of payments.

These practices closely parallel those followed by insurance companies who sell health insurance and other casualty insurance products.

The peer review function for health insurance claims is directly analogous to the automotive casualty insurance adjusters' function. It is critical to ASC to bring to this court's attention the dangers of permitting these functions to escape antitrust examination and scrutiny.

The casualty insurance industry's interests in extending their limited exemption from the application of the United States antitrust laws are not in the best interests of a free competitive marketplace. These misguided private price fixing functions are not in the best interests of the more than 100 million insured motor vehicle owners. They are at cross purposes with our nation's free market philosophy. They are a manifestation of private regulation and control by these giant insurance companies over the business activities of the 40,000 independent and 20,000 franchised new car dealers engaged in the automotive collision repair business.

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[1] Letters of consent are filed with the Clerk.

ASC members have historically opposed any enlargement of the McCarran-Ferguson Act (15 U.S.C. § 1012(b)) antitrust exemption. They recognize that broad enforcement of all antitrust statutes, federal and state, ultimately serve their common good. If these laws are not always a kind of charter of economic freedom, their enforcement frequently deters abuses of that freedom by the powerful.

Through their national organization, ASC members have a vital interest in this appeal. ASC opposes peer review activities which are identified by some as "interpreting and enforcing" functions. They oppose activities which are subtle, if not blatant, price fixing schemes.

ASC supports the respondent's position and the accuracy of the 2nd Circuit Court of Appeals' decision that

> ". . . peer review is not 'the business of insurance' within the meaning of § 2(b) of the McCarran-Ferguson Act, and that defendant's use of the procedure is therefore not immune from scrutiny under the antitrust laws."[2]

ASC's interest in this matter concerns the application of *Royal Drug's* "business of insurance" definition to third party functions because its members are third party contract providers of services to insureds. Additionally, the issues raised by petitioners in applying "the spreading and underwriting of a policy holder's risk" test, enunciated in *Royal Drug*[3] have made ASC's views pertinent.

ASC's concerns relate to the misconceptions about risk spreading and underwriting by the automobile casualty insurance companies and the third party provider relationships.

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[2] *Pireno* v. *New York State Chiropractic Association and Union Labor Life Insurance Co.*, 650 F.2d 387 (2nd Cir. 1981) (Royal Drug) *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979)

[3] 440 U.S. at 211.

Finally, and most important, the status and legal effect of claims adjustment functions, and claims adjusters, which are referred to by the 2nd Circuit Court in dismissing peer review as the "business of insurance," hold significant interest for ASC members.

The base inference that the term "claims adjusting" and any argument that this is within the "business of insurance" exemption needs to be addressed by an industry spokesman directly affected, such as ASC.

The real and present danger of failing to address this issue is the opening and expanding of possibilities that any cost containment activity of an insurance company could escape antitrust scrutiny. The autobody repair industry and ASC's members would then be subjected to even more pervasive private regulation and domination by the insurance companies.

SUMMARY OF ARGUMENT

The meaning of *Royal Drug* is clear, unequivocable and easily understood, regardless of the contrary arguments made by the insurance industry. We submit that the insurance industry and some of its allied professional associations simply do not want to accept the limitations on the antitrust exemption that were enacted into McCarran-Ferguson by Congress and clearly defined by this Court. The Court of Appeals expressed the essence of the matter this way:

> "In *Royal Drug, supra,* the Supreme Court sharply restricted the availability of this antitrust exemption by placing a narrow construction on the statutory concept of the "business of insurance."[4]

The narrow construction of statutory antitrust exemptions is proper and universally followed although the remaining beneficiaries are continually seeking enlargements.

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[4] 650 F2d 387, page 391

Another argument which has been revived in this matter, and which ASC rejects, is that society benefits from cost containment which justifies the price fixing mechanism. This Court clearly disposed of this argument in *Royal Drug*. We argue that the cost containment position is equally without support in law and fact. The collision repair industry is penalized to the extent of depressed wages, earnings and the inability to acquire the needed modern equipment to perform quality restoration of vehicles to their pre-crash value. This is largely caused by the insurer's cost containment. But the real victims are the vehicle owners who collectively suffer multibillion dollar losses in depreciated values of vehicles which are cutrate repaired, and not restored to the value prior to being damaged. No one argues for increased automobile or medical insurance premiums as being beneficial to society. However, cost containment price fixing exacts its toll. A competitive market free of private regulation is the best means for insureds to receive the services that they want, and to which they are entitled under their contracts of insurance.

The insurance policy — the contract between the insured and the insurer — should on its face contain the specific limits to which the insurer is willing to agree to reimburse the insured. If the insurer wishes to cost contain his risk of loss, the insurer should be specific in the policy, otherwise the deductible stated therein becomes a floating, variable amount — depending upon the whims, policies and claims settlement procedures adopted by the insurance company.

It is appropriate that the Circuit Court found "neither risk transference nor risk spreading in the peer review process." Any argument that peer review committees perform this most vital and basic insurance function is not only without merit, but also opens unlimited possibilities of future contingent activities which could escape antitrust scrutiny. This dangerous practice of placing future tests that must be met by the insured or his

provider in order to have an insurable loss or a fully valid claim, by withholding the transfer of risk is unacceptable. As decided below, it simply isn't true. *The amount of loss to the insured should arise from the competitive costs for a quality restoration. Competition, not private regulation or cost containment should be the discipline that determines the amount of loss to be compensated.*

The adjustment function is not the business of insurance that Congress exempted in McCarran-Ferguson. It is not what this Court described as an insurance practice exempted in favor of State regulation. To hold so would be a license to the State insurance regulators to expand their authority to every conceivable function relating to the business of insurance. Claims adjusting is not essential to medical insurance and it is not essential to the auto casualty industry. The internal function of insurance personnel in handling claims is essential but peer review is not, and neither is the use of "preferred shops" adhering to "approved rates" by auto insurers. Computer data on ranges or averages of losses is readily available. Any competent insurer has access to quantities of cost information from a variety of sources, including its own experts, whether medical or vehicular. The Highway Loss Data Institute (HLDI), a joint venture by several large auto casualty insurance companies, has very specific loss data by make and model of car.

ARGUMENT

I. The Antitrust Laws Apply To Third Party Arrangements And Practices Of Insurance Companies Which May Reduce Business Costs But Are Not The "Business Of Insurance"

This Court made it clear that all of the varieties of business arrangements which insurance companies may find in their best interests to make are not within the business of insurance

concept in McCarran-Ferguson.[5] There are no real insurance characteristics in the functions of a peer review committee to make such an arrangement exempt. Arguments are made that peer review directly involves the interpretation and enforcement of the contract of insurance.[6] There may well be within the insurance industry functions of interpretation and enforcement which are the "business of insurance," but the peer review procedure here is not among them. The petitioner, Union Labor Life Insurance Co. (ULL) has taken the position that the peer review committee performs an advisory role, which could be performed by an "in house" or staff chiropractor.[7] The peer review procedure was established by the petitioner, New York State Chiropractic Association, for the benefit of the insurance industry, and it may confer benefits on some of the Association's members.

It does not appear that the ten member review committee was required by or even the direct result of New York State Insurance laws.[8] Indeed, it would have been irrelevant even had it been so required. Also, it does not appear that the peer review procedure was a written prerequisite in the contracts of insur-

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[5] *Royal Drug supra*, at pages 232-33: "If agreements between an insurer and retail pharmacists are the "business of insurance," because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control — whether with automobile body repair shops or landlords. Such agreements would be exempt from the antitrust laws if Congress had extended coverage of the McCarran-Ferguson Act to the "business of insurance companies." But that is precisely what Congresss did not do."

[6] *SEC* v. *National Securities, Inc.* 393 U.S. 453 (1969).

[7] Brief for Petitioner, Union Labor Life Insurance Company, pages 5-6.

[8] New York law merely requires ULL to pay insureds for chiropractic treatment whenever a policy "provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor." 221 (5)(e) (McKinney 1980-81)

ance. The Court of Appeals found that "the peer review committee is not a member of the insurance industry."

This review committee is not the business of insurance, but it is a method of doing business in the insurance industry. The procedure results from the vagueness of the terms chosen for the insurance contracts of *reasonable charges* for *necessary* medical care and not in excess of the *regular* and *customary charges*.[9]

This Amicus takes the position that if insurance companies contract with their insureds and purposely use broad and vague terms in order to limit their liability, and then assume it is necessary to conspire with the provider industries to establish policy limitations, they cannot hide behind the McCarran-Ferguson shield. ASC believes that insurers must include their terms of settlement in their policies. If they want limitations, they must clearly state their intention to restrict their liability at loss time to wage rates which are at the minimum or below the industry averages. They must provide in the contract that they will only reimburse policy holders for auto parts costs which are less than the cost of new parts.[10] It is not essential to the industry to continue to control provider costs. However, where they believe controls are needed, such limits belong up front in clear terms in their contracts. Then insurance companies can compete with each other based on the stated limits of the losses they

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[9] Pireno Joint Appendix; O'Connor Affidavit, page 19a.

[10] See *Quality Auto Body, Inc.* v. *Allstate Insurance Co.*, 1980-2 Trade Cas. (CCH) § 63507 (N.D. ILL. 1980); affirmed 660 F2d 1195 (7th Cir. 1981) The District Court (at page 76,696):

> "An internal document obtained from State Farm details the consequences of an artificially suppressed labor rate on the practices of body shops. When the rate is too low, the shops resort to charging for new but using old parts, estimating parts that are not damaged, straightening old parts but charging for new parts, inflating labor hours, billing for repairs that were not performed and offering rebates and bribes to adjusters. Under such circumstances honest shops may be forced out of business."

promise to pay their insureds — not some variable amount which may or may not reimburse the policy holder for the loss sustained.

It is essential that this court understand the contractual relationship between third party suppliers (such as auto body repair shops) and the insureds. *The vehicle owners, the insureds, are the customers of the body shops — not the insurance companies. The contract of repair is between the vehicle owner and the repair shops — not the insurance company.* If the insurance company elects to repair under the policy, it then becomes the customer of the shop — but this is not the usual or customary practice.

The insurance company is a *functionary* party which is simply returning to an insured a portion of all premium dollars paid to the insurance company for the purpose of spreading the risk of loss. They have no legal basis for becoming the private regulators of the contract between insureds and their suppliers. They have no basis for substituting their self interest, profit biased judgment for determining the terms and quality of performance by third party suppliers to their insureds. Indeed, it is this very self interest by the insurance companies that creates a conflict of interest in this settlement procedure for their own insureds.

II. Peer Review Like Other Third Party Arrangements For The Purpose Of Or To The Effect Of Cost Control Do Not Transfer Nor Spread Risks Of Insurance Companies

The Court of Appeals applied the basic test for ancillary agreements to qualify as insurance and found the peer review procedure outside the protected area. [11] This Court has analyzed

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[11] 650 F2d 393; ". . . an activity or procedure that does not either transfer risk from insured to insurer or spread the risk among insureds is not the business of insurance. We find neither risk transference nor risk spreading in the peer review process." *Royal Drug*, 440 U.S. at 213; Id at 211.

the theory and practice of insurance and the laws applied to this business, and the history and effect of the McCarran-Ferguson Act in three principal cases: *Royal Drug* and *SEC* v. *National Securities, supra;* and *SEC* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65 (1959). The essence of these judicial actions is before the Court in this matter. There have been no abrupt restrictions nor narrowing of the law as some argue, but a steady progression toward an understanding by the industry of what Congress always intended.

ASC is convinced that the review process is not a transferring or spreading of any risk of bearing medical costs but rather serves as an advisory procedure. There are no legal prohibitions or even serious obstacles to the seeking of advice or collection of loss information, as the insurance industry would have this Court believe. Such legitimate functions of the insurance business are a far cry from the extraordinary power placed in the hands of the peer review committee or automotive insurance adjusters following rigid price setting schedules.

This Amicus cannot accept that a maximum (and possibly minimum) fee fixing committee or adjuster with the power to restrain trade by arbitrarily deciding which competitor's services are proper and compensable, can be an exempt "business of insurance" function because it touches, or is a component. [12] Procurement of office space, supplies and other essential operations of insurance companies touch, affect, and are components of the insurance business. ASC believes that the dissenting opinion in *Bartholomew* contains the correct analysis:

> "By extending McCarran Act immunity to the type of conduct alleged here, where both the perpetrators of the

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[12] *Bartholomew* v. *Virginia Chiropractors Association*, 612 F2d 812 (4th Cir. 1979), cert. denied, 446 U.S. 938 (1980) The Fourth Circuit was overly broad in finding peer review exempt because it touched the "business of insurance" and was a component act in the composite business . . . insurance.

conduct and its impact are outside the insurance industry, the majority ignores the purpose of the Act and the *Royal Drug* Court's explicit direction on its construction."[13]

III. Third Party Agreements And Functions For Insureds Are Mistakenly Viewed As Purchases By Insurance Companies.

In progressing to the present state of the law on the insurance exemption as expressed by the Court of Appeals, we believe that a few fictions have evolved. One fiction is that the public (the insureds) cannot be allowed to deal "one on one" with their providers. This has led the insurance companies to assume unto themselves the prerogative of determining what quality restoration is acceptable and at what price. Another fiction is that a little maximum price fixing and restraint of trade by groups of suppliers, induced by agreement or economic force of partially regulated insurers is good for the public. And, of course, the final fiction, described earlier, is that insurance companies are the large-scale purchasers of suppliers' services. Except in rare instances, the insured is the purchaser.

The first fiction has led to a public misperception that people are not totally responsible for their own acts concerning their health and property; that everyone and everything is insured against every loss; and that the insurance company is responsible and always pays. It is likely that this public misperception has increased insurance costs by encouraging unnecessary and exaggerated claims.

The second fiction is characterized by *Arizona* v. *Maricopa County Medical Society*, 643 F2d 533 (9th Cir. 1980), cert. granted USLW 3663 (Mar. 10, 1981) which presents a situation where the evils of fee fixing by a provider body in agreement with the insurers, ultimately raises prices to a noncompetitive level, and adversely affects all purchasers or consumers of the providers' services, whether insureds or uninsureds.

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[13] *Bartholomew, supra*, 612 F2d at 817

The final fiction runs through many of the McCarran insurance-related cases where confusion exists about the point of purchase; who decides upon the type of service; who supplies and who receives the services; and who is ultimately obligated to pay whom for all services. For example, see *Royal Drug, supra,* page 214; "The pharmacy agreements . . . are merely arrangements for the purchase of goods and services by Blue Shield." In particular, it is a misconception in the auto insurance cases such as *Quality Auto Body, Inc.* v. *Allstate Ins. Co.*, (1980-2) Tr. Cas., page 76,693: "Companies that offer to reimburse their policyholders for the cost of services needed after an accident can also be thought of as large scale purchasers of such services." In *Chicks Auto Body* v. *State Farm Mutual Automobile Insurance Co.*, 168 N.J. Super. 68, 401 A2d 722 (Super. Ct. Law Div. 1979), Aff'd, 176 N.J. Super. 320, 423 A2d 311 (Super. Ct. App. Div. 1980) the fiction of a direct buyer-seller relationship led to mistaken reasoning, and caused in part by reliance on decisions such as *Travelers Insurance Co.* v. *Blue Cross of Western Penna* 481 F2d 80 (3rd Cir. 1973) when it equated the auto insurer with a corporate purchaser of medical services. See also discussion of pre 1945 cases in *Royal Drug* concerning advance payment medical benefit plans which function as consumer cooperatives; *e.g. Jordan* v. *Group Health Association*, 71 App D.C. 38, 107 F2d 239 (1939). 440 U.S. at pages 226-28.

CONCLUSION

This Amicus is concerned that the major, underlying issue here, as in similar cases, has been obscured by the partisan, self interest arguments. The insurance industry mistakenly believes it must be protected against all antitrust actions in order to provide adequate public service. The providers are concerned with restraints on their services, their earnings, and their freedom to serve the public. ASC believes that the major issue here is the proper balance, intended by Congress, in the lawful

positions of these related industries. Such balance will allow the interaction of adequate state regulation and federal antitrust laws to serve the true interests of the public.

In conclusion, ASC urges this Court to reject the social benefits and "business of insurance" arguments of petitioners, and to affirm the Second U.S. Court of Appeals and the doctrine of *Royal Drug*.

Respectfully submitted,

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF AMICI CURIAE THE HEALTH INSURANCE ASSOCIATION OF AMERICA AND THE AMERICAN COUNCIL OF LIFE INSURANCE

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BRIEF OF AMICI CURIAE THE HEALTH INSURANCE ASSOCIATION OF AMERICA AND THE AMERICAN COUNCIL OF LIFE INSURANCE

The Health Insurance Association of America ("HIAA") and the American Council of Life Insurance ("ACLI") submit this brief as *amici curiae*, with the consent of all parties.

INTEREST OF AMICI

HIAA is a trade association consisting of more than 300 insurers which account for over 80% of the health insurance written by commercial insurers in the United States. ACLI is a trade association composed of over 500 life insurance companies, many of which write health as well as life insurance and are also members of HIAA.

The issue in this case is whether peer review procedures used as an aid in the interpretation of health insurance contracts are part of the "business of insurance" and so exempt from the antitrust laws, to the extent regulated by state law, pursuant to the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015.

This issue is of great importance to *amici*. Their member companies are regularly called upon, in the conduct of their health insurance business, to review claims for reimbursement and to determine the extent to which their insurance contracts obligate them to honor these claims. In difficult cases, they often use peer review as part of that process.

The peer review procedure at issue in this case is typical of that used by health insurers throughout the country. Although specific wording varies, the typical policy at issue here obligates the insurer to pay "usual, customary and reasonable" fees for "necessary" medical services. Where it appears that a claim may be excessive, the companies sometimes ask the advice of a peer review committee composed of professionals in the appropriate community and health care field. The committee then renders its opinion, which the insurance company is free to use as the basis of its own determination as to whether the terms of the policy are met.

Thus, peer review committees provide an important service for the insurer: informed and impartial advice as to whether an insured's claim for reimbursement reflects only expenses that come within the policy's coverage or includes unnecessary treatments or inflated charges that exceed the insurer's obliga-

tion to pay. There are hundreds of peer review committees throughout the nation rendering such advice at the request of *amici*'s members.

HIAA gathers for its members extensive information on the availability of peer review committees for particular health care fields and localities, and also monitors the effectiveness of the peer review procedure. HIAA has found that peer review is an important aspect of the fair administration of the business of health insurance, and is an important aid in minimizing the inflationary impact of insurance on health care costs.

The decision below, in holding that such peer review activities are not the "business of insurance," exposes insurers and health care professionals to the burdens of antitrust litigation if they participate in a procedure of great importance to the sound administration of health insurance contracts. It thus threatens to chill insurers' use of peer review, to the detriment of *amici*'s members, the insurance business and the public interest. Further, the unduly narrow interpretation given to the "business of insurance" by the decision below threatens to exclude from the McCarran-Ferguson exemption activities of *amici*'s members long considered to be within the "core" of its coverage. That interpretation, for example, led the court below to the conclusion—startling to *amici*—that the entire process of claims settlement might be excluded from the "business of insurance."

Amici are persuaded that the decision below is inconsistent with prior decisions of this Court interpreting the McCarran-Ferguson Act and with the policy of the Act, as explained in those decisions, to leave regulation of activities such as the interpretation of contracts and the payment of claims to state legislatures and insurance departments. Hence, *amici* join with petitioners in urging reversal of the decision below.

SUMMARY OF ARGUMENT

A peer review procedure of the kind involved in this case serves entirely as an aid in interpreting and enforcing the underwriting limits of health insurance policies. Therefore, under this Court's prior decisions in *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.*, 440 U.S. 205 (1979) and *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969), the procedure is plainly part of the "business of insurance" within the meaning of the McCarran-Ferguson Act.

The court below adopted an unrealistically narrow view of the "business of insurance" that was inconsistent with these decisions. It failed to recognize that the "business of insurance" is an integrated process encompassing not only the insurance contract itself but all of those activities closely related to the contract and traditionally in the domain of state regulation, beginning with the formulation of policy terms defining the underwritten risk, continuing through the sale of the policy, and culminating with the interpretation of the policy and the payment of claims. This is the essential point of *National Securities*, as reaffirmed in *Royal Drug*.

The court below also mistakenly concluded that peer review is outside the "business of insurance" because it involves health care professionals who are not part of the insurance industry. In peer review activities of the kind involved here, the sole function of the health care professionals who are members of the committee is to provide advice, at the request of an insurance company, for guidance in the application of the health insurance policy to claims made by insureds. While performing as peer review committee members, health care professionals are not furnishing health care services; rather they are performing a function akin to that of insurance adjusters. The McCarran-Ferguson exemption is claimed here, therefore, solely for activities of the peer review members in helping to interpret the insurance contract—an activity directly within the business of insurance. Application of the exemption

to such activities does not threaten to free from antitrust scrutiny any activities of health care professionals when they step out of this limited role.

ARGUMENT

I

PEER REVIEW IS AN ESSENTIAL AID TO THE IMPLEMENTATION OF HEALTH INSURERS' UNDERWRITING DECISIONS AND TO THE INTERPRETATION AND ENFORCEMENT OF HEALTH INSURANCE CONTRACTS. IT IS THUS AT THE "CORE" OF THE "BUSINESS OF INSURANCE."

For centuries medical societies have used peer review as a device for maintaining professional standards.* This case, however, involves only the use by health insurers of peer review committees for advice in interpreting their health insurance policies. This is a relatively new practice; the first known instance of it occurred in 1945, but it was not in common use until the 1960s. Health Insurance Council, *A Report on Medical Society Review Committees in the United States as Established by Medical Societies* 3-4 (1965) (hereinafter "*HIC Report*"). Encouraged by the Social Security Amendments of 1973, P.L. 92-603, which required the establishment throughout the nation of Professional Standards Review Organizations (PSROs) for use in connection with the evaluation of claims for reimbursement under Medicare and Medicaid, the practice gained widespread use in the private health insurance industry in the 1970s. C. Cissley, *Claim Administration: Principles and Practices* 203 (1980). Use of peer review committees by insurers

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* *See* Meiselman, *The Law of Medical Society Peer Review*, 51 N.Y.S. Bar J. 486, 488 (1979); M. Pollard & R. Leibenluft, *Antitrust and the Health Professions: Policy Planning Issues Paper* 64 (1981) (FTC publication); Health Insurance Council, *A Report on Medical Society Review Committees in the United States as Established by Medical Societies* 3 (1965).

to evaluate especially questionable health insurance claims has, literally, become textbook practice. *See id.* at 202-03; HIAA, *A Course in Group Life & Health Insurance, Part B* 187-89 (1979); C. Stengel, *Claim Administration: Life & Health Insurance* 207-10 (1969); *see also* Chodoff, *Psychiatry and the Fiscal Third Party*, 135 Am. J. Psych. 1141, 1145 (1978).

The structure and procedures of the committees rendering claims advice to insurers differ from place to place. Some committees are composed of practitioners in one health care field, such as podiatry, psychiatry, dentistry, osteopathy, or chiropractic. Others cover a broad range of medical practice, and include one or more specialists in each of a number of fields. But in general, the purpose for which insurers seek the advice of peer review committees is the same: to determine whether a service of the duration and type involved was medically necessary and whether the fee charged was "usual, customary and reasonable" in the particular geographic area. C. Cissley, *Claim Administration, supra*, at 202-03; HIAA, *Manual of Review Committees* 1 (rev. ed. 1979); C. Stengel, *Claim Administration, supra*, at 209.

In *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.*, 440 U.S. 205, 213 (1979), this Court stated that "the underwriting or spreading of risk is a critical determinant in identifying insurance." The Court then went on to reaffirm its earlier definition of the business of insurance in *SEC* v. *National Securities*, 393 U.S. 453 (1969), saying:

> "Another commonly understood aspect of the business of insurance relates to the contract between the insurer and the insured. In enacting the McCarran-Ferguson Act Congress was concerned with:
>
> > 'The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be

> placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder.' *SEC* v. *National Securities, Inc.*, *supra*, at 460."

440 U.S. at 215-16.

A review of peer review's principal functions shows that, as used in this case, it is plainly within these definitions of the "business of insurance."

First, peer review provides insurers with informed, broad-based advice in contract interpretation. This is made necessary by the flexible risk limits of certain health insurance policies, which provide payment for the "usual, customary and reasonable" charges for necessary health care service ("UCR policies").

The flexibility of UCR coverage explains why in the last two decades it has become "the most commonly used method of insurance reimbursement for physicians' services." Z. Dyckman, *A Study of Physicians' Fees* 27 (1978) (Staff Report prepared by the Council on Wage and Price Stablization). The UCR approach is now used for most coverage of major medical expenses. *Id.* at 26. In some cases it is also used for basic coverage, replacing fee schedules that express coverage limits in terms of fixed dollar amounts for various treatments. *Id.* A UCR policy avoids the inequities that arise when a fee schedule fails to keep pace with rising health care prices. More generally, UCR policies avoid the arbitrariness of a fixed schedule, which may bear little correlation to the loss actually suffered by the policyholder. Because it sets policy payments equal to the actual fees reasonably incurred by the policyholder, a UCR policy is carefully tailored to minimize the risk that he must absorb—tailored, that is, to maximize the insurance protection of the policy.

But this same flexibility means that there will often be questions as to whether a claim comes within the bounds of the

policy's coverage. Any policy, of course, requires the insurer to determine whether a claim is covered; in the case of a UCR policy, the room for doubt is great because the insurer must determine the "necessity" of the services performed and the "reasonableness" of the charges. A health insurer cannot have confidence, without more, that its policyholder's decision to use a medical service represents a considered decision as to what is necessary or reasonable; the patient, knowing that a third party has promised to pay the cost of a medical service, has little incentive to decline the service or resist a high fee. *See, e.g.*, Enthoven, *Rx for Health Care Economics: Competition, Not Rigid NHI*, 59 Hospital Progress 44, 44 (1978); Havighurst, *Controlling Health Care Costs*, 1 J. Health Politics, Policy & Law 471, 474-75 (1977); Kennedy, *Public Concern and Federal Intervention in the Health Care Industry*, 70 N.W.U.L. Rev. 1, 2-3 (1975).

The nature of the insurance contract, therefore, compels the insurer to seek an objective opinion as to whether the policyholder has received a necessary medical service at a rate that is reasonable within his area—whether, that is, the policyholder seeks reimbursement for a service covered by the policy. *See HIC Report* at 7. It is for this reason that insurers use peer review. *Id.*

A peer review committee does not define the policyholder's obligation to the service provider or impose any limitation on the fees that providers may charge. Rather, the committee merely considers whether the claim appears to come within the scope of the policy's coverage, and then advises the insurance carrier of its opinion. The carrier may then rely on this conclusion in making its own determination as to whether it is obligated under the policy to pay the full amount of the claim. C. Stengel, *Claim Administration*, *supra*, at 209.

Peer review committees thus serve a function similar to that of claims adjusters, aiding insurers in determining the degree to which reimbursement is appropriate under their contracts of insurance. This, of course, is a necessary function; if the

insurer merely paid every claim without question, the cost of insurance (as well as of health care) would climb without restraint. And if the insurer is to make a considered judgment on the question of whether the requirements of the UCR policy are satisfied, informed medical advice is "[i]ndispensable." *Id.* at 206.*

The insurer could seek similar advice from its own staff, and in many cases its medical department is sufficient. But such staff professionals cannot be expected to be adequately informed to render sound advice in every case. This is especially so because the UCR policy requires an insurer to assess a claim in the context of fees and medical practice prevailing in a particular community, and "[t]here exists considerable variation in the pricing practices of physicians throughout the United States," *HIC Report* at 31. Moreover, to assess the "necessity" for particular services and the reasonableness of the charges for them frequently requires an intimate knowledge of a wide variety of health care fields and specialties, which no one health care professional could possibly possess. To gain informed advice in every case, therefore, would require the insurer to hire on its own staff one or more professionals in each of many widely different fields of medical expertise with detailed knowledge of each geographical area where its policyholders reside. Such a system would plainly be impossible for most insurers.

To evaluate UCR claims adequately and economically, then, it is sometimes necessary in questionable cases for insurers to seek the advice of committees that include independent practicing professionals in particular specialties and communities. Such committees fill the same function that staff professionals

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* By giving insurers a better understanding of the factors that determine "usual and customary" fees, peer review also helps them to make future evaluations of UCR claims in a more informed manner. *See* HIAA, *Manual, supra,* at 1; Health Insurance Council, *Medical Society Review Committees in Action* 4-8 (1969) (panel discussions); B. Richardson, *Settlement Procedures in Life & Health Insurance* 113 (1963).

would, but they are able to provide broader-based and far sounder advice on the medical practices prevailing in a given community and specialty. To this end, HIAA publishes a *Manual of Review Committees* simply so that insurers will know the identity, scope and procedures of peer review committees in each specialty and community.

Peer review also serves another important function affecting the "relationship between insurer and insured." It provides an impartial mechanism, short of litigation, for resolution of disputes relating to the interpretation and enforcement of the policy limits. Indeed, although the peer review committee's decision is not binding on the insurer, the very availability of the procedure is likely to give insureds confidence that their policies will be fairly administered and will protect them against risk.

Finally, peer review serves another function that is crucial to the sound administration of health insurance and of importance to insureds and the public interest as well: it helps minimize abuses of the health insurance policy which subsidize inflated health care costs. As explained previously, third-party payments diminish a policyholder's incentive to resist excessive medical service and fees. Unless proper precautions are taken, therefore, "misuse and abuse of medical care insurance coverage" tends to fuel inflation in the cost of medical care and, inevitably, of insurance. B. Richardson, *Settlement Procedures in Life & Health Insurance* 113 (1963); *accord, e.g.*, Stricker, *Personality Assessment and Insurance Reimbursement*, 42 J. Pers. Assess. 317, 317 (1978) (where mental health claims are paid routinely, appearance is of "a disproportionately costly service that is near impossible to insure"). Insurers' use of peer review is a major element of their response to this problem. *E.g.*, *id.*; B. Richardson, *Settlement Procedures, supra*, at 113; Maguire, *Peer Review in Community Mental Health*, 14 Comm. Mental Health J. 190, 190 (1978); Chodoff, *Psychiatry and the Fiscal Third Party, supra*, 135 Am. J. Psych. at 1145.*

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* Peer review is one of a number of methods used by health insurers in the design and administration of their policies in response to this

The Second Circuit believed that because peer review served such a cost-containment function it was, like the provider agreements in *Royal Drug*, "simply a form of cost reduction" and hence outside the "business of insurance." 650 F.2d at 393. However, there is an obvious and significant difference between the cost-reduction function of peer review and that of the provider agreements in *Royal Drug*.

Unlike the provider agreements in *Royal Drug*, which sought to lower the prices of the drugs that the insurer was obligated to furnish to its insureds, peer review does not fix the price of any goods or services.* Peer review helps contain costs only by enabling an insurer to assess more accurately whether a claim falls outside the policy limits because the doctor charged his patient an unreasonable fee or performed an unnecessary service. Nothing in *Royal Drug* suggests that a procedure such as peer review is excluded from the "business of insurance" merely because, by helping insurers make more informed interpretation of policy limits, it may also help minimize reimbursement of excessive or unreasonable charges.

Furthermore, insurers do not use peer review simply to reduce costs; even an arbitrary system of claims review, devoid of professional expertise, could do that. Rather, peer review provides the *fairest* method of cost containment, sifting out those claims that are truly excessive and so do not come within the terms of the policy. *See* Stricker, *supra*, 42 J. Pers. Assess. at 318 (peer review is "a professional, rather than an arbitrary path towards cost effectiveness").**

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problem. These include coinsurance factors, deductibles, non-duplication provisions, and clauses requiring a second opinion as a pre-condition to reimbursement of surgical claims. HIAA, *A Course in Group Life & Health Insurance, Part B* 124-26, 187-97 (1979).

* Nor does respondent make any claim that petitioner New York State Chiropractic Association ("NYSCA") sets such price levels. The only alleged impact on competition from NYSCA activities is the result of insurers' decisions, made on NYSCA's advice, with respect to individual policy claims.

** In some cases peer review, rather than reducing costs, thus may result in payment by the insurer of a claim that otherwise it might have refused to pay.

Health insurers have not been alone in recognizing the value of peer review in coping with the problem posed by third party payments of medical expenses. In 1967, the National Advisory Commission on Health Manpower—a presidential panel consisting of doctors, public health administrators, and others—issued a comprehensive report dealing, *inter alia*, with the problem of curtailing unjustified reimbursement of health insurance claims. The Commission studied in depth the use of peer review by private insurers and concluded that "professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care." 1 National Advisory Commission on Health Manpower, *Report* 48 (1967). For example, the Commission recommended that "[p]eer review should be widely applied to hospital utilization," because its use is an important "safeguard" against overutilization. *Id.* at 68, 69.

Governmental recognition of this fact has gone beyond mere recommendation. Through the Medicare, Medicaid, and Maternal and Child Health programs, the federal government is itself the largest third-party reimburser of medical expenses. Congress has recognized that "a significant proportion of the health services provided under medicare and medicaid are probably not medically necessary." S. Rep. No. 1230, 92d Cong., 2d Sess. 254 (1972). It has been recognized that the "proliferation of third-party mechanisms" is one of the major causes of "rapidly mounting costs in the health care industry as well as documented examples of fraudulent or, at the very least, unnecessarily excessive behavior on the part of providers of health care." Kennedy, *Public Concern and Federal Intervention*, *supra*, 70 N.W.U.L. Rev. at 2-3.*

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* *Accord, e.g.* Schweiker, *"The Age of Competition in Health Care* 5-6 (address, Jan. 8, 1982, by Sec. of Health & Human Services) (Medicare and Medicaid, together with growth of private insurance, "removed many of the financial barriers to seeking health care"); *Health Agency Proposes Cost Controls,* Journal of Commerce, Dec. 29, 1981, p. 7A (summarizing Dept. of HHS report to Cabinet on methods of limiting inflationary impact of insurance on health care costs).

Congress regarded the problem as "extremely significant," S. Rep. No. 1230, *supra*, at 254, and believed that "only physicians are, in general, qualified to judge whether services ordered by other physicians are necessary." *Id.* at 256. Accordingly, Congress drew on the Health Manpower Commission's report, *id.* at 256-57, and provided in P.L. 92-603, 42 U.S.C. § 1320c, *et seq.*, for "the establishment of independent professional standard review organizations (PSRO's) by means of which practicing physicians would assume responsibility for reviewing the appropriateness and quality of the services provided under medicare and medicaid." S. Rep. No. 1230, *supra*, at 257. The PSROs, which now operate throughout the nation, "have broad authority to assure that only those services that are medically necessary and consistent with professionally recognized standards of care will be reimbursed by a federal health program." Note, *Cost and Quality Control in the Medicare/Medicaid Program: Concurrent Review*, 11 Harv. C.R.C.L.L. Rev. 665 (1976).

In sum, the peer review activities of the kind involved here are an integral part of the process of interpretation and enforcement of the health insurance contract, providing a fair procedure for resolving disputes between insurer and insured, implementing the underwriting and risk transfer decisions reflected in the insurance contract and minimizing the abuse of the insurance contract as a source of inflated health care charges. Peer review is of great importance to the health insurance business, to insureds and the public interest. It is most certainly and quintessentially the "business of insurance" as that term has been defined by this Court.

II

THE SECOND CIRCUIT'S DECISION UNDULY NARROWS THE McCARRAN-FERGUSON ACT AND EXCLUDES PRACTICES COMMONLY UNDERSTOOD TO BE PART OF THE "BUSINESS OF INSURANCE."

The conclusion of the court below that peer review falls outside the "business of insurance" rests on an unduly narrow reading of the McCarran-Ferguson Act that would exclude from the Act not only the peer review procedure at issue here but many other practices commonly understood to be part of the "business of insurance." We believe that reading reflects a misunderstanding of this Court's decision in *Royal Drug*.

Referring to the statement in *Royal Drug*, 440 U.S. at 213, that "the underwriting or spreading of risk is a critical determinant in identifying insurance," the Second Circuit concluded that "an activity or procedure that does not either transfer risk from insured to insurer or spread the risk among insureds is not the business of insurance." 650 F.2d at 393. The Second Circuit applied this conclusion in an extraordinarily narrow way, stating that peer review has no role in the spreading of risk, *id.*, and declaring:

> "Peer review takes place only after the risk has been transferred by means of the policy, and . . . is thus not a means of transferring risk from insured to insurer. At most, it is an aid in determining the scope of the transfer after it has been made."

Id.

If this unrealistic distinction were consistently applied, many activities previously held by this Court to be within the "business of insurance" would now be excluded. For example, in *National Securities*, this Court said that the "business of insurance" left to state regulation embraces such activities as "[t]he selling and advertising of policies, *FTC* v. *National Casualty Co.*, 357 U.S. 560 (1958), and the licensing of

companies and their agents, cf. *Robertson* v. *California*, 328 U.S. 440 (1946)." 393 U.S. at 460. Yet none of these activities in themselves spread or transfer risk; hence, under the decision below they would all be outside the business of insurance. Indeed, although the court below recognized that the ratemaking process is part of the "business of insurance," 650 F.2d at 392, the logic of its opinion might lead to the opposite conclusion—for no risk is actually spread or transferred by the mere acts of collecting data and of setting a rate. Rather, those acts would be considered "[a]t most . . . an aid in determining the [price] of the transfer [before] it has been made"—and so *not* a part of the "business of insurance."

Indeed, the only activity that would be the "business of insurance" would be the actual delivery of the policy from the carrier to the insured, for it is only by that act that the risk is actually transferred or spread; as the Second Circuit itself stated, the risk is transferred "by the very purchase of insurance." 650 F.2d at 393.

The Second Circuit's error, of course, lay in its failure to recognize that, precisely because peer review aids in determining the scope of the transfer of risk from insured to insurer, it helps define the "relationship between insured and insurer," and assists the interpretation and enforcement of the policy, *National Securities*, 393 U.S. at 460; it is therefore, like other aspects of claims adjustment, a "link in the process of insurance," C. Cissley, *Claim Administration, supra,* at iii, by which insurers effectuate the "underwriting or spreading of risk."

The Second Circuit mistakenly seemed to believe that *Royal Drug* and *National Securities* were in conflict. The conclusion in *Royal Drug* that "the underwriting or spreading of risk is a critical determinant in identifying insurance," 440 U.S. at 213, did not detract from the declaration in *National Securities* that "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation and enforcement . . . were the core of the 'business of insur-

ance,' " 393 U.S. at 460. *Royal Drug* quoted this statement approvingly. By doing so, it reaffirmed that the "business of insurance" consists of a continuous process of activities relating to an insurance contract—that is, a contract involving "the underwriting or spreading of risk."

That process begins with the formulation of the policy, which defines the scope of the transferred risk and the price for the transfer; it continues through the "selling and advertising of policies, *FTC* v. *National Casualty Co.*, 357 U.S. 560 (1958)," *National Securities*, 393 U.S. at 460; and it culminates with the interpretation and enforcement of the policy—a step that of course includes the settlement and payment of claims.

This view of the "business of insurance" as a continuous, integrated process is consistent with the use of that phrase in *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944) ("*SEUA*"), the case that led to the McCarran-Ferguson Act. In holding that the "business of insurance" is part of interstate commerce and hence subject to the antitrust laws, the Court rejected the notion that insurance could be broken down into a series of unconnected local transactions. Rather, the Court characterized the insurance business as "a continuous and indivisible stream of intercourse among the states composed of collections of premiums, payments of policy obligations, and the countless documents and communications which are essential to the negotiation and execution of policy contracts." 322 U.S. at 541; *see id.* at 537 ("the insurance business . . . include[s] not only the execution of insurance contracts but also negotiations and events prior to execution of the contracts and the innumerable transactions necessary to performance of the contracts. All of these alleged transactions . . . constituted a single continuous chain of events . . . .").

The result in *SEUA* aroused concern that it would create "inroads . . . on the tradition of state regulation of insurance. The McCarran-Ferguson Act was the product of this concern." *National Securities*, 393 U.S. at 458. Prior to *SEUA*, "States had a free hand in regulating the dealings between

insurers and their policyholders." In enacting the McCarran-Ferguson Act, Congress sought "to turn back the clock, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation." *Id.* at 459.

Ratemaking activities were a primary topic of Congressional debate because they had been at issue in *SEUA*. *See National Securities*, 393 U.S. at 458-60. But as enacted, the statute did not mention ratemaking or any other particular aspect of insurance. Rather, it adopted the broad term, "business of insurance," that had been used in *SEUA*, *e.g.*, 322 U.S. at 548. No member of Congress ever suggested that this term was to have a novel or restrictive meaning in the statute; indeed, the legislators never even discussed its meaning in their debates. It follows that Congress must have intended the term to have a meaning similar to that in *SEUA*, where it covered the entire process of insurance.

That this process includes the interpretation and enforcement of the insurance contract, as stated in *National Securities*, is confirmed by one of the earlier drafts of the Act, submitted by the National Association of Insurance Commissioners ("NAIC") in November 1944. As this Court has noted, "The views of the NAIC are particularly significant, because the Act ultimately passed was based in large part on the NAIC bill." *Royal Drug*, 440 U.S. at 221. This bill did not purport to grant the business of insurance a complete exemption from the Sherman and Clayton Acts, but among the activities that it would have exempted were "any cooperative or joint service, adjustment, investigation, or inspection agreement relating to insurance, or to acts under such agreements." 90 Cong. Rec. A 4406 (1944). There is no indication that, in choosing the more general phrase, "business of insurance," in place of the activities listed in the NAIC bill, Congress intended to exclude such commonly understood aspects of the business of insurance from the coverage of the Act.

The legislative history, then, demonstrates that the "business of insurance" was meant to include the entire process of

insurance involving not only the contract of insurance itself, but those activities related to the contract including the interpretation and enforcement of the contract and the payment of claims. Because insurers use peer review as an integral part of the adjustment process, the conclusion follows that the practice falls within the "business of insurance." *See, e.g.*, C. Cissley, *Claim Administration*, *supra*, at 202-03; C. Stengel, *Claim Administration*, *supra*, at 207-10; B. Richardson, *Settlement Procedures*, *supra*, at 112-14 (discussing peer review as part of the claim settlement process).

The Second Circuit acknowledged that peer review "performs an 'adjusting' function commonly performed by insurance company personnel," 650 F.2d at 394. Nevertheless, it declined to hold insurers' use of peer review to be part of the "business of insurance," stating:

> "First, it is by no means clear that claim-settlement itself constitutes 'the business of insurance' within the meaning of the antitrust exemption as interpreted in *Royal Drug*. Second, it remains true that the peer review committee is not a member of the insurance industry, and that the antitrust exemption seeks primarily to shield agreements among insurers, not those between insurers and persons outside the industry."

Id. at 394-95 (citations omitted). We believe that neither of these views is sound.

A. *Claim Settlement.*

As noted, the legislative history of the McCarran-Ferguson Act and prior decisions of this Court make it plain that claim settlement is a part of the "business of insurance." Indeed, the possibility that the entire claim settlement process might be excluded from the "business of insurance" is a novel suggestion to those in the industry, and is contrary to common understanding. It is hornbook law that adjustment of claims is "incidental and essential to [an insurance company's] operation." 2 G. Couch, *Cyclopedia of Insurance Law* 206 (2d ed.

1959). In settling and paying a claim, the insurer is fulfilling its primary obligation under the policy; it is hard to name a practice that has a more direct bearing, in any type of insurance, on "[t]he relation between insurer and insured." Typically, "[a] large part of [an insurance] policy describes procedures for loss adjustment." R. Mehr & E. Cammack, *Principles of Insurance* 213 (7th ed. 1980). For example, in the most commonly used fire insurance policy, set forth in N.Y. Ins. L. § 168, seventy-one of 165 lines deal with settlement of claims. *Id.*

That claim settlement is intimately tied to the insurance contract was a point made in the industry while the McCarran-Ferguson Act was under consideration:

> "There is a contractual relationship between the claimant and the insurance company. Their rights and obligations are defined by the policy contract and, it is the duty of the claim department to see that the contractual obligations are lived up to, not only by the claimant but by the company also."

McGettigan, *We Must Reform A. & H.*, 73 Insurance Field 6 (December 15, 1944). More recently a leading authority put the point this way:

> "Claim administration is the last link in the process of insurance—a process that begins with actuarial analysis and continues through sales, underwriting, investment, and policy service. . . . [T]he expectation of the policyowner that an insurer is willing to meet its obligations, through claim administration, is an important part in the decision to purchase insurance. Indeed, it is the claim administration function that delivers on the product sold to the policyowner."

C. Cissley, *Claim Administration*, *supra*, at iii.

Moreover, claims procedures influence underwriting as much as they are influenced by it. Rates are, of course, dependent on loss experience, and so "claims procedures . . .

are an important determinant of commonly made rates and the spreading of risks." *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, (CCH) 1980-81 T.C. ¶63,591 at 77,139 (D.D.C. 1980), *appeal docketed* (D.C. Cir. Nov. 14, 1980). "Underwriting," it has been said, "is the pre-claim stage." Dingman, *Comments on Claim Service*, in International Claim Association, *Proceedings* 54, 54 (1930).

Underwriting and claim adjustment, then, are together integral parts of the process by which risk is transferred. "The close cooperation between claims and underwriting, to a large degree, is responsible for the success of [the insurance] business." Forsythe, *Claim and Underwriting Departments—Coordination* 3 (address on file in College of Insurance Library, New York 1953).

It is therefore not surprising that claims adjustment is, and for decades has been, an important focus of state insurance regulation. *See, e.g.*, N.Y. Ins. L. § 40-d (McKinney's 1980); 40 Pa. S. §§ 301-308; Ohio Rev. C. Ann. ch. 3951; National Convention of Insurance Commissioners ("NCIC"), *Report of the Committee on Industrial Health and Accident Settlements* (recommending legislation), in 2 NCIC, *Proceedings* 5 *et seq.* (1911); *id.* at 2 (resolution endorsing recommendations).* There can be no question, then, but that claim settlement procedures, which vitally affect the relationship between insurer and insured and have always been a focus of state regulation, fall within the "business of insurance" as that term was used by Congress when it enacted the McCarran-Ferguson Act.

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* It is clear that the New York Superintendent of Insurance has ample power to prevent the procedure from resulting in the improper denial of claims. N.Y. Ins. L. § 40-d prohibits "unfair claims settlement practices," including the following:

> "c. failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies;
>
> "d. not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear; . . ."

Article IX-D of the Insurance Law, §§ 270-282, authorizes the Superintendent to investigate and enjoin such practices.

B. *Industry Personnel*

As noted, the Second Circuit also suggested that the peer review procedure, although part of the claim settlement process, is not within the "business of insurance" because "the peer review committee is not a member of the insurance industry." 650 F.2d at 395.

In reaching this conclusion, the Second Circuit relied on a statement in *Royal Drug* suggesting that an alternative ground for holding the provider agreements beyond the "business of insurance" might be that they were not "wholly intra-industry." 440 U.S. at 225 n.32. But that statement provides no support for the conclusion drawn by the court below.

The contracts in *Royal Drug* were not "intra-industry," this Court explained, because they were made with entities selling not insurance but rather pharmaceutical "goods and services." *Id.* The contracts themselves merely called for the provision of such goods and services. It was thus the nature of the activities at issue, and not any talismanic label that might be applied to the participants, that determined the non-insurance character of the *Royal Drug* agreements.

The peer review procedure here, by contrast, is an insurance activity because its only function is to render advice on the meaning and application of an insurance contract. While the committee members are chiropractors, peer review does not call upon the committee to render any chiropractic service to the insured or to the insurer. The facts that the committee's members are not on the payroll of an insurance company and that they may practice chiropractic when they are not serving on the committee do not alter the character of the committee's advisory service. No exemption is sought here for the members of the peer review committee for activities beyond the furnishing of this service.

To exclude the peer review procedure challenged here from the "business of insurance" on the ground that the process uses health care professionals who are not on an insurance company payroll is illogical. Such a result would abandon the principle of *National Securities* that the McCarran-Ferguson Act "refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the *business* of insurance.' " 393 U.S. at 459 (emphasis in *National Securities*). Nothing in *Royal Drug* supports this result.

CONCLUSION

As the District Court in this case recognized, peer review fits within the "core of the business of insurance" as previously defined by this Court, because it enables an insurer "to define the precise extent of [an insurer's] contractual obligations to its insured under their policies" and its function is to provide "interpretation of the contractual relationship between insurer and insured." (CCH) 1979-2 T. C. ¶ 62,758 at 78,377.

The Court of Appeals for the Fourth Circuit came to the same conclusion, noting that peer review is part of "an integration of component acts resulting in a single, composite business—insurance." *Bartholomew* v. *Virginia Chiropractors Ass'n*, 612 F.2d 812, 817 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980). So too did the District Court in *Gerimonte* v. *Washington Chiropractors Ass'n, Inc.*, No. C81-40R (W.D. Wash. Oct. 16, 1981), *appeal filed* (9th Cir. Nov. 27, 1981), which recognized, slip op. at 5, that:

> "The peer review system serves to determine the extent of the insurers' contractual obligations to their policyholders. . . . The interpretation of the terms of the policy, which will in turn determine the rights of the policyholder, is of direct and immediate concern to the insured."

The Second Circuit, in reaching the opposite conclusion, adopted a narrow and unrealistic view of the "business of insurance" which would exclude from the McCarran-Ferguson Act a practice of importance to the administration of health insurance contracts and which would to a large extent eviscerate the Act.

For these reasons, the decision below should be reversed.

January 1982

Respectfully submitted,

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Amicus Brief

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NO. 81-389
NO. 81-390

IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY AND
NEW YORK STATE CHIROPRACTIC ASSOCIATION,
PETITIONERS
V.
A. ALEXANDER PIRENO, RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF AMICUS CURIAE, THE LEGAL FOUNDATION OF AMERICA, URGING REVERSAL

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BRIEF OF AMICUS CURIAE, THE LEGAL FOUNDATION OF AMERICA, URGING REVERSAL

CONSENT OF PARTIES

All parties have consented to the filing of this brief. Letters of consent have been lodged with the Court.

INTEREST OF AMICUS CURIAE

The Legal Foundation of America ("LFA") is a non-profit corporation designated as a public interest law firm by the Internal Revenue Service.[1] Its goals, among others, include preservation of the market system of resource allocation, removal of unnecessary regulation, and attainment of a federal system in which the States and the national government each respect the other's

1 "Public interest law firm" is a technical term defined by IRS regulations. The Mountain States Legal Foundation and the American Civil Liberties Union are other examples of public interest law firms with very different purposes (neither is related to LFA).

appropriate roles. All litigation undertaken by LFA is approved by its Board of Trustees, a majority of whom are attorneys.

LFA has taken active interest in preserving rational function of the market in both insurance and health care. Proper construction of McCarran-Ferguson is an economic necessity if the market system is to work effectively. Construction of the Act should be neither too broad nor too narrow. LFA submits that the Court of Appeals interpreted the Act too narrowly, and that unless this Court reverses, the insurance industry will be prevented from fulfilling its function effectively.

STATEMENT OF THE CASE

An express exemption from the antitrust laws is provided by the McCarran-Ferguson Act for the "business of insurance." The issue here is whether insurance contract enforcement by submission to peer review for advice whether health care charges are "usual," "customary," and "reasonable" within the meaning of the policy constitutes the "business of insurance."

The process begins with the issuance of a policy of insurance. A covered consumer consults the specialist of his choice. He later makes his insurance claim. In case of doubt whether the charge is "usual, customary and reasonable" within the meaning of the policy, the parties[2] may obtain a non-binding advisory opinion from a peer review committee composed of practitioners. As a result, the insurer may pay only that portion of the claim that is deemed within the coverage contracted for, with the insured to pay the rest. The insurer does not thereby set prices for any good or service. Specifically, there is nothing in the peer review process that limits the amount that a willing consumer can pay the practitioner of his choice; the consumer is limited only by his own economic motivations in the marketplace.[3]

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2 There is nothing inherent in peer review that would make it useful only for an insurer, and a consumer or health care provider could use it too. Indeed, the record shows that Pireno himself invoked it.

SUMMARY OF ARGUMENT

Amicus curiae will not attempt to duplicate the case-law arguments expected to be made by the parties. Instead, Amicus will add analysis bearing upon the Congressional purpose.

"Externalities," or factors external to the price system, can cause even competitive markets to malfunction. There is evidence Congress had this effect in mind when it enacted McCarran-Ferguson.[4] The institution of insurance is useful because it buffers businesses and consumers against externalities in the form of catastrophic losses. But unless limits on the contract of insurance are accurately enforceable, insurance can itself create externalities of the sort Congress was concerned about, in that it causes the rational consumer to ignore the balance of resources expended and marginal satisfaction obtained. Peer review addresses this externality without diminishing consumer sovereignty, and indeed while enhancing it. It is an effect peculiar to, and inherent in, the "business of insurance."

PRELIMINARY STATEMENT

An express exception to the antitrust laws is at issue in this case.[5] The economic analysis contained in this brief is not an ef-

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3 The insurer does, thereby, allow market forces to induce the consumer to balance incremental commitment of resources against marginal benefit. As a result, price is ultimately set by supply and demand. But this means nothing more nor less than that the market system is working. One of the ironies of this case is that plaintiff objects precisely to this market function. See note 25 below and text thereto.

4 See Text accompanying notes 16-25 below.

5 Thus the case at bar is distinguishable from such decisions as National Gerimedical Hospital v. Blue Cross, 49 U.S.L.W. 4672 (U.S.S. Ct. June 15, 1981). In that case, the Court declined to infer an antitrust exemption argued by the insurers to arise from the National Health Planning and Resources Development Act of 1974, which, unlike the McCarran-Ferguson Act, contains no express exemption.

fort to argue that such an exception should exist, since that argument has already persuaded the Congress. Instead, this analysis is directed at determining the proper scope of the exemption, an analysis that may be assisted by understanding its purposes.

As this brief shows, McCarran-Ferguson is consistent with classical economics. This honorable Supreme Court has cited extensively from the works of economists in interpreting statutes with economic purposes.[6] In addition to Congressional sources, this brief relies principally upon two works that have probably taught more students the subject than any other: the basic Economics text of Professor Samuelson of M.I.T. and *The Price System* by Professor Dorfman of Harvard.[7]

ARGUMENT AND AUTHORITIES

I. CHARACTERISTICS OF THE BUSINESS OF INSURANCE THAT PROMPTED CONGRESS TO PASS THE McCARRAN-FERGUSON ACT

The antitrust laws attempt to preserve a system with vigorous competition among a large number of sellers.[8] This policy is based on the premise that such a system will bring about various kinds of economic efficiency,[9] including those associated with

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6 E.g., Permian Basin Area Rate Cases, 390 U.S. 747 (1968) (citation of economic works in discussion of "just and reasonable" rates for natural gas).

7 P. SAMUELSON, ECONOMICS (6th ed. 1964)[hereinafter cited as SAMUELSON]; R. DORFMAN, THE PRICE SYSTEM (1964)[hereinafter cited as DORFMAN].

8 See, e.g., SAMUELSON ch. 24.

9 These efficiencies include (1) production of the precise mix of goods and services demanded by the population as a whole, (2) production of the maximum output of this mix that is feasibly attainable, and (3) allocation of production by consumers to themselves so as to maximize satisfaction within income constraints. DORFMAN ch. 6.

consumer sovereignty. But this premise is itself based upon several assumptions about the nature of markets that require exceptions when they fail, as they do in the business of insurance.

A. Market Failures or "Externalities"

The market theory assumes that both businesses and consumers are motivated by rational economic considerations. For businesses, this assumption amounts to the postulate that firms maximize long-term profits.[10] For consumers, it assumes that they seek maximum satisfaction (an idea called the "nonsatiation principle").[11] The rational consumer has a supply of "dollar votes," and he expends them in a pattern that is automatically keyed to economic efficiency in the whole economy.[12] Furthermore, the rational consumer responds to the law of diminishing returns. When he receives diminishing satisfaction from increasing quantities of a given good or service, he adjusts the number of dollars expended upon it, and the amount consumed, accordingly.[13]

These assumptions, however, are only assumptions. Sometimes the price system does not conform to them because of what economists call "externalities"—i.e., factors external to the price system, for which that system does not provide adequate countervailing incentives. A classic example of an externality is

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10 SAMUELSON 488-89.

11 DORFMAN 46.

12 DORFMAN 4-10, 44.

13 When a consumer has relatively little of a given good, he is very desirous of having more, and he is therefore willing to sacrifice relatively large quantities of other goods to obtain it. But when he has a great deal of it relative to other goods, additional increments become less desirable, and they do not motivate him to sacrifice so large a quantity of other goods. In economic jargon, it is said that "indifference curves" are "convex" and that there is ultimately a "declining marginal rate of substitution." DORFMAN 49. The potential difficulty of insurance, as is shown below, is that it removes this effect.

air or water pollution. Another externality, of interest in this case, is observed when individual consumers' purchases of a given item are subsidized without practical limits, so that the rational consumer is motivated to consume indefinite amounts of it without regard for diminishing satisfaction or for the resources thus committed to its production. That possibility is created by insurance.

B. Externalities Peculiar to Insurance

Externalities Mitigated by Insurance. Insurance is useful because if it did not exist, the price system might fail to correct against externalities in the form of catastrophic losses. Efficient firms would be haphazardly destroyed, and with this knowledge, businessmen would be less motivated to maximize profits in the long term, preferring quicker returns instead. Whenever the occurrence of individually unpredictable losses is sufficiently predictable in the aggregate to enable its indemnification to be accurately priced, there is a possibility that insurance can reduce the externalities associated with such disasters and make markets work more efficiently.[14]

Externalities Created by Insurance. But at the same time, by its very nature, insurance strikes at the heart of the market system by its own peculiar brand of externality. Specifically, it indefinitely subsidizes the consumer's purchase of goods and services to repair the effect of the catastrophe. Unless this subsidy is limited by enforcement of the contract, given the nonsatiation principle, the assumption of economically efficient behavior in the marketplace would fail.[14a] This effect is peculiar to, and inher-

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14 SAMUELSON 421-22.

14a See notes 11-13 above and accompanying text. SAMUELSON 422 explains the peculiar relationship of diminishing marginal utility to the institution of insurance. The rational consumer in such a situation would insist on world-famous medical skills and up-to-the minute electronic gear, regardless of the sacrifice of resources. But he would not

ent in, the "business of insurance."[15]

C. Congressional Purposes Underlying the McCarran-Ferguson Act: "Failures" in the Market

McCarran-Ferguson is thus consistent with sound economic theory, and there are indications that Congress had this consistency in mind. Peculiarities of insurance were emphasized in debate. As Senator Ferguson himself observed, "The sale of insurance is not the same as the sale of an article in a store."[16] Because of its differences from other markets, the ordinary approach of antitrust to the insurance market would be inappropriate. Senator Ferguson drew attention to the problem of "failures" in the market.[17] His concern was not merely with rates, but also with the threat to solvency posed by the uncertainty of "losses."[18] Proponents[19] and opponents[20] each argued the merits of

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stop there. He would, quite rationally, demand that his specialist have fine carpeting on the floor of each room and walls decorated with masterful paintings to provide pleasant atmosphere. If sacrifice of other purchases is not required to obtain such small incremental benefits, the non-satiation principle predicts this exact behavior.

15 An analogy to this effect of insurance might be found in a NASA purchase of technology advancing the state of the art, done on a cost-plus contract. Outside such government purchasing and certain social welfare spending, no other institution is so dependent as is insurance upon third-party choices of expenditure levels. The peculiarity with insurance is not merely that the third party or his agent is in near-exclusive possession of relevant information, nor is it merely that the third party and the payee have no incentive to balance resources against benefits. The striking fact is that the third party and payee have an actual disincentive from doing so.

16 91 Cong. Rec. 1481 (1945).

17 Id.

18 Id. See also Id. at 1486 (remarks of Senator Radcliffe).

19 E.g., Id. at 1483 (remarks of Senator Radcliffe, pointing out that insurance industry has low barriers to entry compared to, for example,

the Act in economic terms. Although the initial motivation of McCarran-Ferguson was exclusively that of restoring the regulatory balance to the States, the antitrust immunity was supported in the end not merely by this federalist purpose, but also by "a substantive judgment that it was not sound policy to apply the antitrust laws in the insurance market."[21] The policy basis is demonstrated by reasoning such as Senator Ferguson's remarks about failures in the market, a notion corresponding to the economist's concept of externality.

II. ENFORCEMENT OF THE CONTRACT OF INSURANCE AS DISTINGUSHED FROM RESTRAINTS ON OTHER MARKETS: THE ISSUE OF CONSUMER SOVEREIGNTY

Limits of This Analysis of Insurance. Nothing in this analysis necessitates restraints on other markets beyond those that would be imposed by rational consumption. The goal of insurance contract enforcement is prevention of the externality of indefinite subsidy of consumption; contract enforcement need not seek to diminish consumer choice. For example, it would not be necessary, in enforcing the contract of insurance, for the insurer to set maximum drug prices or force druggists to follow them.[22] That

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steel; noting effects of excess profits, if they occur; discussing potential competition; and arguing that McCarran-Ferguson Act would not have effect of diminishing competition owing to "character of the insurance business"); cf. Id. at 1485-86 (remarks of Senator O'Mahoney that "salutary combinations" would mitigate "economic power" and that without the Act, "comprehensive service . . . to the insuring public" would "[come] second").

20 E.g., Id. at 1479, 1481 (remarks of Senator Pepper concerning prospect of "excess profits," competition and benefits of market system).

21 Note, The Business of Insurance Under the McCarran-Ferguson Act After Royal Drug, 80 COLUM. L. REV. 1475, 1483 (1980).

22 For this reason, the case at bar is entirely different from Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 99 S. Ct. 1067, 59

would not be the business of insurance; it would instead be an interference with consumer sovereignty in the drug market. An insurer attempting to set prices might effectively limit the druggist to carrying only a standard item (such as generic aspirin), when the consumer might desire to spend his dollars for high-purity aspirin (Bayer), or buffered aspirin (Bufferin), or a non-aspirin analgesic (Tylenol).[23]

Enforcement of Indemnity Limits. But an insurer *is* carrying out the "business of insurance" when it contracts for a given level of payment and pays no more than that level to the consumer, after allowing the consumer to select the quantity and quality of goods and services and to pay, himself, any increment over the indemnity he will receive. That is what the insurer does when it contracts for and insists on paying the "usual, customary and reasonable" cost of health care services. A consumer so insured can still contract for *de luxe* goods or services (as opposed to merely usual, customary and reasonable ones) by adding his payment to cover the amount by which the more expensive services he desires exceeds the indemnity.[24] Thus he can contract with a

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L. Ed. 2d 261 (1979). The distinction is properly made in Bartholomew v. Virginia Chiropractors Ass'n, 612 F.2d 812, 817 (4th Cir. 1979), which is consistent with the economics underlying insurance.

23 See SAMUELSON 385-90 (critique of interferences with functioning market responding to supply and demand). Refusing to allow market forces to work to influence consumer choices ultimately interferes with consumer sovereignty, and that result would follow from indefinite subsidy of consumption, as is shown below.

24 This practice is common and familiar to both patients and health-care providers. It is so common, in fact, as to be arranged by bank credit card coverage of surcharges. Health care providers even advertise the arrangement in television schedule magazines, such as the following, which appeared during the week this brief was completed in draft:

> "... We will take your dental insurance up front....
> "... SURCHARGES, IF ANY, MAY BE PAID BY VISA, MASTERCARD OR PERSONAL CHECK. OTHER CREDIT IS ALSO AVAILABLE...."

physician or chiropractor who sees few patients, attends seminars monthly, maintains up-to-the-minute electronic equipment, or even has an expensively decorated office to soothe patients. But such a consumer would be motivated to consider the marginal benefit obtained against the resources expended. That result is nothing more nor less than proper function of the market, buffered against the externality of casualty. Thus the peer review arrangement is appropriate because of the peculiarity of insurance that is mentioned above—namely, the problem of indefinite consumption subsidy—and not because of anything peculiar to the health care industry. Contract enforcement to avoid this externality is part of the hard core business of insurance.[25]

Infringement of Consumer Sovereignty in the Absence of Enforcement of Indemnity Limits. Unless indefinite consumption is avoided by contract limits, an infringement of consumer sovereignty would naturally result. This seeming paradox resolves itself when one considers the rational consumer making a choice as to insurance purchases. Consumers should, and do,[26] have a vari-

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TV Chronilog, Jan.3-9, 1982, at 33 (Houston Chronicle Jan.3).

25 At bottom, the theory of the complaint in this case is that the market system should not function. It is that resource-intensive services ("high quality medical care") should be consumed without the consumer's having to consider marginal costs. The same fallacious reasoning is behind the following: "A policy that pays only the 'usual' charges for a service will induce policyholders to avoid patronizing more expensive providers. . . . [I]ncreases that might occur will be hampered." COLUMBIA NOTE, supra note 21, at 1487. But such an "inducement" is proper market function if it is done by the consumer's balancing of marginal resources against marginal benefit, and it is therefore hardly appropriate to call this effect "hampering."

26 Individual insureds may exercise only limited direct choice over health plans. But their employer makes the choice in the marketplace as their surrogate, considering whether additional dollars expended in health care insurance would be preferable to additional wages. In this sense, individual insureds should, and do, exercise consumer sovereignty.

ety of choices in insurance. They can purchase inexpensive insurance from a company with lesser coverages or more expensive and more complete coverage. They can choose between major medical or total care coverage, and between high and low deductibles. They can obtain minimum automobile limits of $ 10,000, or they can pay greater premiums to purchase limits of $ 100,000, $ 250,000, or even $ 1 million. They can accept or reject automobile medical, collision, uninsured motorist, or comprehensive coverage. But if indemnity limits on such contracts were not enforceable, there would be only one kind of insurance available: extremely expensive coverage, because every individual's most rational motivation would be to consume maximum available resources unrestrained by consideration of declining marginal return.

Infringement of Consumer Sovereignty by Discouragement of the UCR Policy. In fact, the logical effect of plaintiff's arguments in this case would be to discourage use of the UCR policy. Fixed-payment policies might be readily enforced, but the UCR policy would not be. At least one advocate of narrow McCarran-Ferguson interpretation has forthrightly recognized the result. COLUMBIA NOTE, supra note 21, at 1487. (The Court of Appeals relied heavily on this Note, citing it at six points in its opinion.[27]) The Note contains the frank but startling statement that "a UCR policy itself exceeds the bounds of the business of insurance." Such reasoning would lead to an anomalous restriction of consumer sovereignty, because the UCR clause is used in the vast majority of health policies.[28] This overwhelming popularity means that the consumer has chosen the UCR policy over other contract forms in the marketplace. Thus plaintiff's argument would countermand consumer choice—and without application of McCarran-Ferguson

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27 The Court of Appeals declined to address this point and hinted possible disagreement. 650 F.2d at 394 n.11. But the point is central to the Note's conclusions, and the Court of Appeals' reliance on the Note is thus difficult to square with this reservation.

28 It provides flexibility to cover losses of any amount up to policy limits but does so at the lowest feasible premium.

in this case, the antitrust laws would achieve an effect precisely opposite from their purpose—a decrease in consumer sovereignty.

CONCLUSION

The peer review process is thus not an inquiry into prices that can properly be agreed to in the marketplace. It is instead an inquiry into the amount of indemnity payable. To put the matter another way, this case does not concern whether the health care industry needs (or does not need) to restrain its prices, or whether automobile repairs, drugs, chiropractic or physical therapy cost too much or too little. These charges should find their level in the marketplace, under the same laws applicable to markets generally. But these should not be markets, as plaintiff would have them, in which there is indefinite subsidy of consumption.

That is why the present case is a case concerning the "business of insurance" and is subject to an express exception from the antitrust laws. It concerns a matter squarely within the scope of an externality peculiar to, and inherent in, the business of insurance. The decision of the Court of Appeals should be reversed.

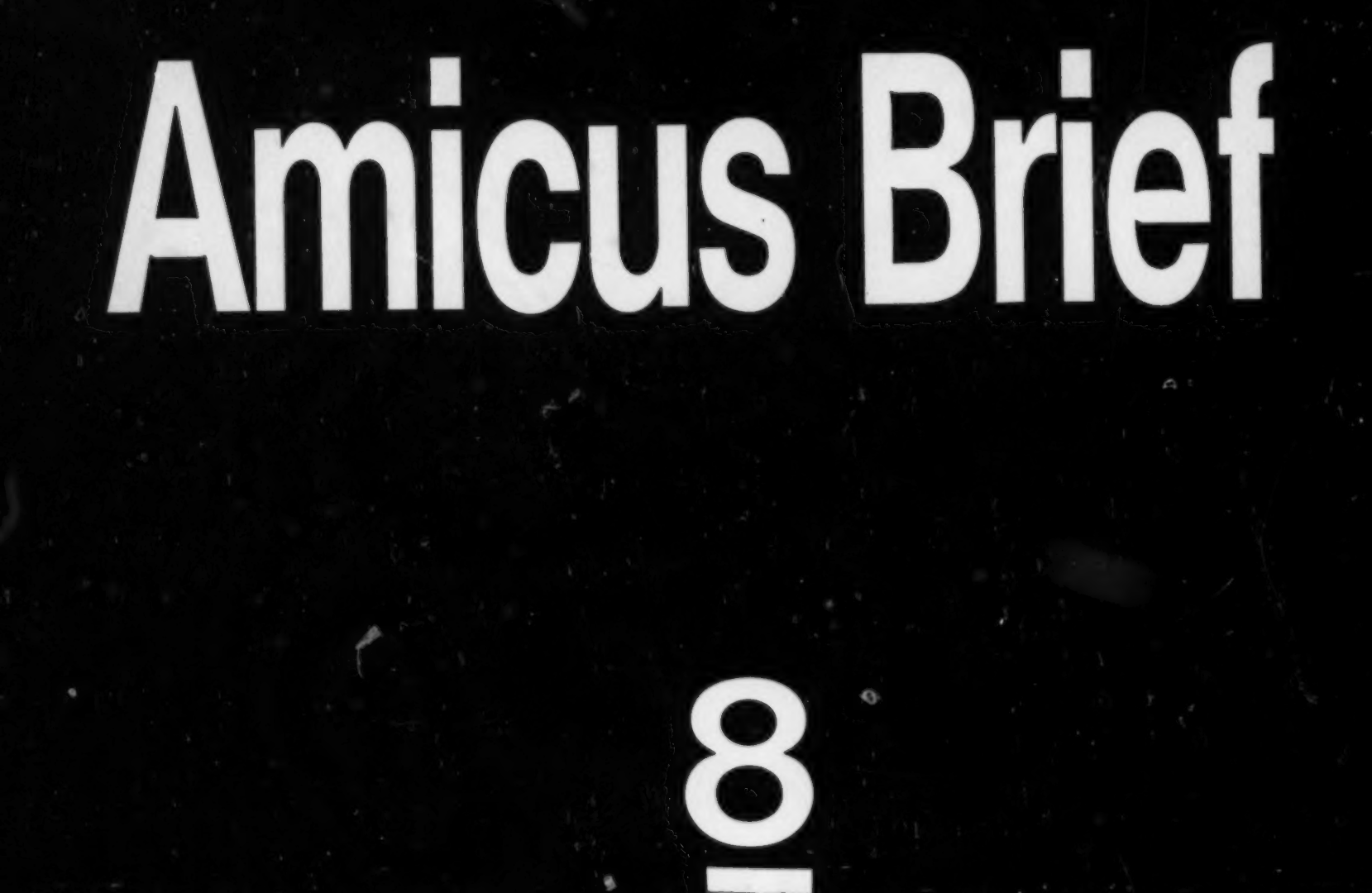
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No. 81-389

UNION LABOR LIFE INSURANCE COMPANY, *Petitioner,*

vs.

A. ALEXANDER PIRENO, *Respondent.*

No. 81-390

NEW YORK STATE CHIROPRACTIC ASSOCIATION, *Petitioner,*

vs.

A. ALEXANDER PIRENO, *Respondent.*

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

AMICUS CURIAE BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF PETITIONERS

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In the Supreme Court of the United States

October Term, 1981

No. 81-389

UNION LABOR LIFE INSURANCE COMPANY,

Petitioner,

vs.

A. ALEXANDER PIRENO,

Respondent.

No. 81-390

NEW YORK STATE CHIROPRACTIC ASSOCIATION,

Petitioner,

vs.

A. ALEXANDER PIRENO,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

AMICUS CURIAE BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICUS CURIAE*

The National Association of Insurance Commissioners (NAIC) is an unincorporated association whose membership consists of the principal state insurance regulatory officials charged by law with the responsibility of regulating the business of insurance within each state, territory and insular possession of the United States. The NAIC submits this *amicus curiae* brief in support of Petitioners and with the consent of all parties to the case.

The individual state insurance commissioners who comprise the NAIC and the insurance consuming public, on whose behalf they regulate, have a vital interest in the outcome of this case. The effect of the lower court's ruling would be to allow policyholders to sue insurers under federal antitrust laws whenever an insurer's interpretation of policy coverage at the claims settlement stage relies on expertise outside the insurance industry. Such an approach is inconsistent with this Court's previous interpretations of the McCarran-Ferguson Act exemption from antitrust liability for activities that are the "business of insurance," "regulated by State law" and not "boycotts."

Since each state regulates the business of insurance as intended by Congress under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15 (1980), an interpretation of that Act which modifies or diminishes the present scope of state insurance regulation would seriously impair the ability of each member of the NAIC to oversee the business of insurance. Affirmation by this Court of the rationale underlying the Second Circuit Court of Appeal's decision would, in the opinion of the NAIC, lead to such an impairment. For this reason the NAIC submits this brief as *amicus curiae*.

ISSUE PRESENTED

Does an insurer's use of a committee of licensed chiropractors to interpret insurance policy provisions limiting coverage to "reasonable" charges for chiropractic services fit within the McCarran-Ferguson Act antitrust exemption for conduct that is the "business of insurance," "regulated by State law," and not a "boycott"?

SUMMARY OF ARGUMENT

The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15 (1980), exempts from antitrust liability activities that are the "business of insurance," "regulated by State law," and not a "boycott."[1] The NAIC contends that an insurer's use of a committee of licensed chiropractors to interpret insurance policy provisions limiting coverage to "reasonable" charges for chiropractic services fits within this McCarran-Ferguson antitrust exemption.

Petitioners' challenged activities qualify as the "business of insurance" as this Court has defined that term in *Royal Drug Company, Inc. v. Group Life & Health Insurance Co.*, 440 U.S. 205 (1979) and its predecessor cases. This Court in *Royal Drug* held that pharmacy provider agreements functioned merely as cost-containment devices, a "business of the insurance company," rather than the "business of insurance." *Id.* at 232. The instant case is distinguishable: the chiropractic peer review board functions as an insurance claims adjuster, determining whether, and to what extent, the insurance con-

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[1] Note, *Clarification of the McCarran-Ferguson Act's Antitrust Exemption for the Business of Insurance: Group Life & Health Insurance Co. v. Royal Drug Co.*, 33 SW L. J. 1093, 1096 (1979). *See also* Royal Drug Company, Inc. v. Group Life & Health Co., 440 U.S. 205, 207 (1979).

tract covers the specific claim. Reviewing claims, whether by the traditional adjuster or by a necessary dependence on the special expertise of health care professionals, is a part of the "business of insurance" rather than a separate business of an insurance company such as the procurement of drugs. The NAIC urges this Court to adopt the adjuster analysis as a supplement to the rationale of *Royal Drug,* a building block in the necessary resolution of the exact boundaries of the *Royal Drug* antitrust exemption for the "business of insurance." This Court can adopt the adjuster analysis without retreating from the rationale of *Royal Drug* or defeating the public policy objectives of effective state regulation of the "business of insurance" to achieve cost-containment in the health care area.

Petitioners' challenged activities also meet the McCarran Act requirement of "regulated by State law," 15 U.S.C. § 1012(b) (1980). Although this Court has never established an articulated criteria for what constitutes regulation by state law under the McCarran Act, lower federal courts have ruled that state regulation exists within the meaning of the Act if a state law "proscribes, permits or authorizes" certain conduct on the part of insurance companies. This standard is met in the instant case because the use of the "regular, customary and reasonable" language by Petitioner Union Labor Life (ULL) is authorized by the laws of the State of New York as well as most other states. That regulation exists in the form of state statutes requiring insurers to submit their health insurance policies and Blue Shield subscriber contracts to the state insurance commissioner for approval prior to marketing.

Furthermore, ULL's use of Petitioner New York State Chiropractic Association's (NYSCA) peer review board

to interpret the policy reference to "regular, customary and reasonable" chiropractic fees is also subject to state regulation. This regulation flows from the state unfair trade practice laws governing unfair claim settlement practices of insurers. These statutes, in New York and elsewhere, are patterned after the NAIC Model Unfair Trade Practices Act which requires insurers to adopt reasonable standards for the payment of insurance claims. In the instant case the peer review procedure is the mechanism for implementing the reasonable standards required by state insurance laws.

Finally, Petitioners' challenged activities do not constitute a "boycott" within the meaning of this Court's interpretation of that term under the McCarran Act. Because there is no "refusal to deal" with Respondent by Petitioner ULL or Petitioner NYSCA, a critical element of this Court's definition of a "boycott" is absent in this case. Neither Petitioner ULL nor Petitioner NYSCA have any voice in the selection of Respondent's services by patients. Moreover, the activities of the NYSCA peer review committee in this case clearly reflect an effort to reimburse Respondent — and thus "deal" with him — even if Respondent's patients do not receive full reimbursement for his services.

Thus, Petitioner ULL's use of Petitioner NYSCA's peer review committee to interpret policy provisions limiting coverage to "reasonable" charges for chiropractic services fits within the McCarran Act antitrust exemption for activities that are the "business of insurance," "regulated by State law," and not a "boycott."

ARGUMENT

I. THE CHALLENGED ACTIVITIES OF PETITIONERS FIT WITHIN THE McCARRAN-FERGUSON ANTITRUST EXEMPTION FOR THE "BUSINESS OF INSURANCE" AS DEFINED BY THIS COURT.

Both historically and in the recent case of *Royal Drug Company, Inc. v. Group Life & Health Insurance Co.*, 440 U.S. 205 (1979), this Court has interpreted the McCarran-Ferguson Act exemption from federal antitrust laws for the "business of insurance" to include the interpretation of insurance policy provisions. The Second Circuit in the instant case limited this principle, holding that the use of a peer review committee of licensed chiropractors to interpret insurance policy provisions limiting coverage to "reasonable" charges for chiropractic services does not constitute the "business of insurance." *Pireno v. New York State Chiropractic Ass'n*, 650 F.2d 386, 395 (2d. Cir. 1981). Consequently that court found that the McCarran-Ferguson Act offered no protection from antitrust challenge to the insurer's contested activities. This conclusion resulted from the court's failure to find any meaningful distinctions between the provider agreements in *Royal Drug* and the peer review procedures in the instant case.

As *amicus curiae* the NAIC submits that the Second Circuit's application of the *Royal Drug* holding and its predecessor decisions to the instant case is faulty. There are distinctions that make a difference between the pharmacy purchasing agreements in *Royal Drug* and the peer review agreements in the case at bar. The proper functioning of the insurance concept is dependent upon the contested activities of the instant case. These activities

necessarily fit within the parameters of the "business of insurance" exemption defined by this Court in *Royal Drug*.

A. *Scope of the "Business of Insurance" Antitrust Exemption as Interpreted by this Court in* Royal Drug

This Court in *Royal Drug* relied heavily on two earlier Supreme Court definitions of the "business of insurance." In *SEC v. Variable Annuity Life Insurance Co.*, 359 U.S. 65, 71 (1959) the "underwriting of risks" was established as "one earmark of insurance as it has commonly been conceived of in popular understanding and usage." The Court found the challenged activities in *Variable Annuity* not to involve the underwriting of risks and therefore not the "business of insurance." *Id.* at 73.

In *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969) this Court offered a more comprehensive definition of the McCarran-Ferguson "business of insurance" exemption:

> Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. Certainly the fixing of rates is part of this business; that is what *South-Eastern Underwriters* was all about. The selling and advertising of policies . . . and the licensing of companies and their agents, . . . are also within the scope of the statute. Congress was concerned with the type of state regulation that centers around the contract of insurance. . . . *The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement — these were the core of the "business of insurance."* 393 U.S. at 459-60 (emphasis added).

National Securities specifically included within the "business of insurance" the interpretation of an insurance policy. That decision also established the proper analysis of challenged activity to determine its inclusion in this exemption. The basic question is whether the challenged activity involves the foregoing *Royal Drug* concept of *"[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement. . .".*

In the *Royal Drug* case this Court refined the "business of insurance" exemption established by *Variable Annuity* and *National Securities.* The *Royal Drug* case arose in the context of an insurer's use of pharmacy provider agreements to keep down the prices it paid for prescription drugs. *Royal Drug* involved an antitrust challenge to Blue Shield's activities in agreeing with selected pharmacies to sell prescription drugs to Blue Shield policyholders for a flat $2.00 charge per prescription. Blue Shield would additionally reimburse the pharmacies for their costs in acquiring the drugs. A Blue Shield policyholder also had the option of obtaining drugs from pharmacies not a part of this agreement, but the cost of the drug to the policyholder would then be substantially greater. Several nonparticipating pharmacies challenged these agreements as antitrust violations.

On these facts this Court found the "business of insurance" exemption not to apply in *Royal Drug,* ruling that a substantial effect on rates, standing alone, is not enough to qualify an activity for antitrust immunity under the McCarran Act:

> If agreements between an insurer and retail pharmacist are the "business of insurance" because they reduce the insurer's cost, then so are all other agreements insurers may make to keep their costs under

> control. . . . Such agreements would be exempt from the antitrust laws if Congress had extended the coverage of the McCarran-Ferguson Act to the "business of insurance companies." But that is precisely what Congress did not do. 440 U.S. at 232.

Thus, the *Royal Drug* analysis restricts the application of the McCarran-Ferguson Act antitrust immunity if the sole basis for finding immunity is the cost-reducing characteristic of third party provider arrangements.

B. *Distinction Between* Royal Drug *and the Instant Case*

The district court in the instant case found distinctions between the *Pireno* peer review procedure and the *Royal Drug* pharmacy provider agreements. The *Royal Drug* provider agreements "were unrelated to the underwriting or spreading of risks among its insureds and were merely arrangements enabling Blue Shield to purchase goods and services, and thereby fulfill its underwriting obligations at reduced costs." *Pireno v. New York State Chiropractic Ass'n,* [1979] 2 TRADE CASES (CCH) ¶ 62,758 at 78,376 (S.D.N.Y., March 17, 1979). In contrast, the peer review procedure is a method

> to define the precise extent of ULL's contractual obligations to its insureds under their policies. Peer review may enable ULL to reduce its costs, but it does so through interpretation of the contractual relationship between insurer and insured. *Id.* at 78,377.

The district court likens the role of the peer review board to that of "the licensed adjuster, long an important figure in the settlement of claims against insurers." *Id.* The lower court's analysis not only reflects sound insurance theory but is also a proper application of this Court's standards for "the business of insurance" in *Royal Drug.*

This Court in *Royal Drug* emphasized "[t]he significance of underwriting or spreading of risk as an indispensable characteristic of insurance. . . ." 220 U.S. at 212. The Court defined insurance as "an arrangement for transferring and distributing risk." *Id.* at 211. Thus, the nexus between the underwriting and distribution of risk in the insurance contract and the peer review procedure significantly determines whether the peer review procedure should fall within the "business of insurance" antitrust exemption. The underwriting and distribution of risks in an insurance contract occurs when an insurance company offers its insureds "a small, definite cost (the premium)" in exchange for "a large but uncertain loss."[2] The insurer uses the insurance contract to define the parameters of the risk the company has accepted. An insurance adjuster interprets the limits of the risk as defined by the contract and pays the policyholder accordingly. This is the proper functioning of the insurance concept.

The traditional licensed insurance adjuster "[d]etermines whether and to what extent coverage and liability exist . . . after analyzing contracts and the evidence accumulated."[3] If his activities fall within the "business of insurance," then so must the activities of the peer review committee of the case at bar. Petitioner ULL relies on the chiropractic peer review committee for the adjuster function because the traditional adjuster lacks the variety and depth of knowledge required for adjusting medical claims.[4] In the instant case the peer review committee,

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[2] R. MEHR & E. CAMMACK, PRINCIPLES OF INSURANCE 19, 32 (15th ed. 1972).

[3] W. ROKES, HUMAN RELATIONS IN HANDLING INSURANCE CLAIMS 3 (3d ed. 1971).

[4] *See* J. DONALDSON, CASUALTY CLAIM PRACTICE 672 (3d ed. 1976).

when adjusting claims, considers:

> the practitioner's experience and specialty degrees; the location of his office; the number of visits and amount of time spent with the patient; the patient's age, occupation, general physical condition and history of prior treatment; and x-ray findings. *Pireno v. New York Chiropractic Ass'n,* [1979] 2 TRADE CASES (CCH) ¶ 62,758 at 78,375 (S.D.N.Y., March 17, 1979).

A committee of licensed chiropractors is certainly more qualified to review and rule on these types of factors than is the traditional insurance adjuster.

Although the provider agreements in *Royal Drug* functioned to contain costs, a provider agreement is just one of many ways for the insurance company to cut costs. The peer review procedures in the instant case, on the other hand, function not only to contain costs, but also as the *only* realistic way to interpret the parameters of the risk shifted from the insured to the insurer. Because of the special nature of medical services, peer review procedures must be substituted for insurance adjusters. The insurer must look to a board of reviewers to determine the necessity of a chiropractic procedure and the reasonableness of its cost because the insurer has no medical expertise to evaluate the application of its indemnity contract to particular insureds/patients. Thus, the use of peer review procedures is absolutely necessary for the proper functioning of the insurance concept, *i.e.,* the transfer of large, unpredictable risks from the insured to the insurer.

The Fourth Circuit Court of Appeals has recognized the difference between provider agreements and the type of peer review procedures involved in this case. That

court's analysis in *Bartholomew v. Virginia Chiropractors Ass'n,* 612 F.2d 812 (4th Cir. 1979) construed the provider agreements in *Royal Drug* as the procurement of drugs which followed the offering of insurance, as opposed to determining what is insured through the use of a peer review committee to pay claims. According to the Fourth Circuit, the peer review situation, "is an integration of component acts resulting in a single, composite business — insurance," whereas in *Royal Drug,* "there were two segregated and disparate operations: one, the offering of insurance, and the other, the procurement of drugs, admittedly an act only thinly tangential to insurance." *Id.* at 817. The Fourth Circuit ruling in *Bartholomew* relied on the *Royal Drug* distinction between the "business of insurance" and the "business of insurance companies."[5] The court contrasted obtaining drugs under the provider agreements, a "business of the insurance company," to the payment of claims through use of a peer review board, the "business of insurance." Thus, the adjuster analysis discussed above has been accepted by at least one circuit court as a basis for finding peer review activities the "business of insurance."

C. *Implications of the Claims Adjuster Analysis for Future McCarran Act Applications*

This Court in *Royal Drug* expressed a concern for fashioning a definition of the McCarran-Ferguson "busi-

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[5] According to the *Royal Drug* analysis,

> [i]f agreements between an insurer and retail pharmacists are the "business of insurance" because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control — whether with automobile body repair shops or landlords. Such agreements would be exempt from the antitrust laws if Congress had extended the coverage of the McCarran-Ferguson Act to the "business of insurance companies." But that is precisely what Congress did not do. 440 U.S. at 281.

ness of insurance" exemption that would open the door to include every business activity an insurance company might choose to pursue. *See* 440 U.S. at 215. The instant case offers facts conducive to the structuring of a "principled basis upon which a line can rationally be drawn" between true insurance activities and mere business activities of insurance companies. *Id.* at 232, n. 40. The NAIC urges this Court to adopt the claims adjuster analysis as a supplement to the rationale of the *Royal Drug* case. That is to say, any activities serving the claims adjuster function should fall within the "business of insurance" concept because an adjuster specifically defines the contractual relationship between insurer and insured. The adjuster, by deciding who shall bear the loss, performs an activity that clearly involves the underwriting of risk in a significant manner.

Several lower court decisions have applied the foregoing adjuster analysis to the benefit of insurance consumers. The Fourth Circuit in *Bartholomew v. Virginia Chiropractors Ass'n,* 612 F.2d 812 (4th Cir. 1979) applied the adjuster analysis to a factual situation involving a peer review procedure similar to the one in the case at bar. That court found that the claims adjuster analogy applied and ruled against the five chiropractors seeking to use the antitrust laws to raise their prices. *Id.* at 817. Similarly, in *Ratino v. Medical Service of the District of Columbia,* [1981] 1 TRADE CASES ¶ 61,144 at 76,857 (D. Md. June 30, 1981), a surgeon brought an antitrust challenge to the "usual, customary and reasonable" reimbursement plan of the Medical Service Corporation of the District of Columbia. The court applied the adjuster analysis of the *Bartholomew* case and rejected the surgeon's attempt to exclude the procedures from the "business of insurance" antitrust exemption. *Id.* at 76-860. Finally, an Ore-

gon district court has applied the adjuster analysis to thwart an attempt by a group of podiatrists to use the federal antitrust statutes to attack limitations on reimbursement for their services created by a price review procedure.[6] *See Hahn v. Oregon Physicians' Services,* 508 F.Supp. 970, 975 (D. Ore. 1981).

The recent case of *Arizona v. Maricopa County Medical Society,* 643 F. 2d 553 (9th Cir. 1980), *cert. granted,* 49 U.S.L.W. 3663 (1981), presents this Court with an excellent opportunity to demonstrate the validity of the insurance adjuster analogy as a supplement to the *Royal Drug* analysis of the "business of insurance" exemption. The *Maricopa County* case involves an insurer's use of maximum fee schedules agreed upon by a group of physicians. The State of Arizona challenges the arrangement, alleging that it operates to fix prices at a level above the average fees charged by Arizona doctors. *Id.* at 555. The application of the adjuster analysis to the *Maricopa*

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[6] The procedures complained against conditioned coverage of podiatric services on physician referrals for the treatment. The court found that "the alleged restraints are an integral part of the risk of covering care to the foot." 508 F. Supp. at 974. *But cf. Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia,* 624 F.2d 476 (4th Cir. 1980), refusing to allow antitrust exemption to a bill review procedure that required physician approval for payment for psychologists' services. However, a rigorous application of the claims adjuster analysis would cause a different result in the *Virginia Academy* case. The bill review procedure is a special type of adjusting practice in which the billing reviewer, the physician, is an adjuster whose task is limited in investigating the justifications of a bill for services about which the physician has expert knowledge. The insurer found the physician (usually a psychiatrist) adequately trained to determine if a psychologist's treatment was "medically necessary" and thus covered by the insurance policy. The insurer simply used physicians as claims adjusters because of their special expertise. *See* Comment, *The Scope of the "Business of Insurance" Provision of the McCarran-Ferguson Act: Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia,* 65 MINN. L. REV. 1187, 1202-03 (1981).

County facts results in an exclusion of the physician fee-setting activity from the antitrust "business of insurance" exemption. The fee-setting activity does not fulfill the claims adjuster function because it occurs *prior* to the insured making a claim against the insurance company. Unlike the peer review procedure in the case at bar, the fee-setting activity in *Maricopa County* advances no legitimate risk-spreading purpose. Thus, the insurer in *Maricopa County,* like the *Royal Drug* insurer, engages in "two segregated and disparate operations . . . one, the offering of insurance, and the other, the procurement of [physician services]. . . ." *Bartholomew v. Virginia Chiropractors Ass'n,* 612 F.2d at 817.

Applied to *Maricopa County*, the adjuster analysis does not prevent the application of the federal antitrust statutes to thwart health care providers' attempts to use price fixing agreements as a sword against health care consumers. This Court can adopt the claims adjuster analysis without retreating from the specific rationale of *Royal Drug* or defeating the public policy objectives of effective state regulation of the "business of insurance" to achieve cost-containment in the health care area. Often the "business of an insurance company" is also the "business of insurance." The adjuster analysis is one of many ways to include an activity in the "business of insurance" definition without impeding legitimate antitrust claims. It is not an analysis to cover every fact situation, but it is a step in the right direction, a building block in the process of establishing clearer boundaries for the "business of insurance" antitrust exemption. Thus, the NAIC urges this Court to adopt the claims adjuster analysis as a building block in the necessary resolution of the exact boundaries of the *Royal Drug* antitrust exemption for the "business of insurance" under the McCarran-Ferguson Act. Since this Court's decision in *Royal Drug* commentators have complained that "the boundaries of the nar-

rowed (business of insurance) exemption are blurred."[7] The case at bar presents an ideal factual basis for detailing one portion of the boundary of the *Royal Drug* "business of insurance" exemption.

II. THE CHALLENGED ACTIVITIES OF PETITIONERS IN THIS CASE ARE REGULATED BY STATE LAW.

The foregoing analysis has shown how Petitioners' activities in this case fit within this Court's definition of the "business of insurance" in the McCarran Act. The second prerequisite for an antitrust exemption under the Act is that the activities comprising the "business of insurance" be regulated by state law. *See* 15 U.S.C. § 1012(b) (1980). Applied to the facts of this case, if the "regular, customary and reasonable" language in ULL's insurance policy and the peer review activities of NYSCA are regulated by New York insurance law, Petitioner's Sherman Act action must be dismissed. As an association of state officials charged by law with the regulation of the business of insurance, the NAIC states unequivocably that the challenged activities of Petitioners in this case are regulated not only by the insurance laws of the State of New York, but by the insurance laws of most other states as well.

A. *Criteria for "Regulated by State Law"*

Although this Court has had numerous opportunities

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[7] Comment, *The Scope of the "Business of Insurance" Provision of the McCarran-Ferguson Act: Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 65 MINN. L. REV. 1187, 1195 (1981). *See also* Note, *Royal Drug and McCarran Act Protection: The Exception or the Rule? — Group Life & Health Insurance Co. v. Royal Drug Co.*, 29 DePAUL L. REV. 147, 162-163 (1979); Note, *Insurance Provider Agreements Subject to Antitrust Scrutiny*, 17 HOUSTON L. REV. 643, 658-659 (1980).

to interpret the scope of the antitrust exemption for the "business of insurance" under the McCarran Act, it has yet to establish an articulated criteria for what constitutes regulation by state law under section 2(b) of the McCarran Act. 15 U.S.C. § 1012(b) (1980). Nevertheless, in *Federal Trade Commission v. National Casualty Co.*, 357 U.S. 560, 564 (1958) this Court held that a state which enacts "prohibitory legislation . . . and authoriz[es] enforcement through a scheme of administrative supervision" satisfies the section 2(b) proviso of the McCarran Act. Although appropriate to the facts of the *National Casualty* case, the Court's holding should not be viewed as the sole standard for determining the meaning of "regulated by State law" under the McCarran Act.

Since the promulgation of the McCarran Act in 1945 lower federal courts have had an opportunity to further develop criteria for what constitutes state regulation under the McCarran Act. While not inconsistent with the holding in the *National Casualty* case, the criteria fashioned by these lower courts offer a better standard for determining the existence of state regulation than the holding of that case. In *California League of Independent Insurance Producers v. Aetna Casualty & Surety Co.*, 175 F.Supp. 857, 860 (N.D. Cal. 1959) a federal district court first ruled that state regulation exists within the meaning of the McCarran Act if a state law "proscribes or permits or authorizes" certain conduct on the part of insurance companies. This standard has received widespread acceptance by other circuit and district courts which have been confronted with the McCarran Act

"regulated by State law" issue. *E.g., Crawford v. American Title Insurance Co.,* 518 F.2d 217, 218 (5th Cir. 1975); *Addrisi v. Equitable Life Assurance Society,* 503 F.2d 725, 728 (9th Cir. 1974), *cert. denied,* 420 U.S. 929 (1975); *Ohio AFL-CIO v. Insurance Rating Board,* 451 F.2d 1178, 1181 (6th Cir. 1971). *See also Holly Springs Funeral Home, Inc. v. United Funeral Service, Inc.,* 303 F.Supp. 128, 135 (N.D. Miss. 1969); *Gerlach v. Allstate Insurance Co.,* 338 F.Supp. 642, 649-50 (S.D. Fla. 1972). Thus, the "proscribes, permits or authorizes" standard is an appropriate reading of the McCarran Act requirement since it recognizes that state regulation can both prohibit undesired conduct and require desired conduct on the part of insurance companies. The NAIC suggests that this criteria be employed by the Court in judging whether particular conduct comprising the "business of insurance" is regulated by state law under the McCarran Act.

B. *Specific Conduct of Petitioners Regulated by State Law*

Respondent alleges that Petitioners' conduct in this case constitutes a conspiracy to fix prices in violation of section 1 of the Sherman Act. 15 U.S.C. § 1 (1980). Respondent specifically objects to the use of the "regular, customary and reasonable" language in Petitioner ULL's insurance policy and the peer review committee of Petitioner NYSCA to interpret such language. Applying the

criteria discussed above for what constitutes "regulation" under the McCarran Act, it is clear that both types of activities are "regulated" by the state of New York as well as most other states.

1. *ULL's "Regular, Customary and Reasonable" Language is "Authorized" by State Law*

A critical element of Respondent's argument is that the "regular, customary and reasonable" language in Petitioner ULL's insurance policy hinders Respondent's practice of chiropractic medicine in the State of New York. Because reimbursement for Respondent's charges by Petitioner ULL is predicated upon the "reasonableness" of those charges, the existence of the "reasonableness" standard is "conduct" on the part of ULL which Respondent challenges as violative of the federal antitrust laws. The use of the "regular, customary and reasonable" language in the ULL insurance policy is clearly "authorized" by the insurance laws of the state of New York, however. New York, like most other states, requires insurance companies to submit their accident and health insurance policies[8]

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[8] N.Y. INS. LAW § 154 (McKinney 1966). In addition to New York, 48 states grant the commissioner of insurance authority to review and approve accident and health insurance policies: ALA. CODE § 27-14-8; ALASKA STAT. ANN. § 21.42.120; ARIZ. REV. STAT. ANN. § 20-1110; ARK. STAT. ANN. § 66-3209; CAL. INS. CODE § 10327 (West); COLO. REV. STAT. §10-8-102; CONN. GEN. STAT. ANN. §38-165; DEL. CODE ANN. tit. 18, § 2712; FLA. STAT. ANN. § 627.410; GA. CODE ANN. § 56-2410; HAWAII REV. STAT. § 431-495; IDAHO CODE § 41-1812; ILL. REV. STAT. ch. 73, § 143; IND. CODE ANN. § 27-8-5-1; IOWA CODE § 515.109; KAN. STAT. ANN. § 40-2215; KY. REV. STAT. ANN. § 304.14.120; LA. REV. STAT. ANN. § 22:620; ME. REV. STAT. ANN. tit. 24A, § 2412; MD. ANN. CODE art. 48A, § 375; MASS. GEN. LAWS ANN. ch. 175, §108; MICH. COMP. LAWS ANN. § 500.2236; MINN. STAT. § 62A.02; MO. REV. STAT. § 376.405; MONT. REV. CODES ANN. § 33-15-301; NEB. REV. STAT. § 44-348; NEV. REV. STAT. § 687B.120;

and Blue Shield subscriber contracts[9] to the Superintendent of Insurance for approval before they can be marketed in the state. These policies represent the specific type of insurance coverage that applies to Respondent's services in this case. Since the ULL policy in question — including its "regular, customary and reasonable" reimbursement language — was filed and approved under New York insurance laws it represents "conduct" of Petitioner ULL that has been "authorized" by state law. Consequently, this Court should find the "regular, customary and reasonable" language exempt from Respondent's antitrust challenge because it is regulated by state law within the meaning of section 2(b) of the McCarran Act.

(Footnote 8, cont'd)
N.H. REV. STAT. ANN. § 415:1; N.J. STAT. ANN. § 17B:26-1; N.M. STAT. ANN. § 59-18-2; N.C. GEN. STAT. § 58-54; N.D CENT. CODE § 26-03-42; OHIO REV. CODE § 3923.02; OKLA. STAT. ANN. tit. 36, § 4402 (West); OR. REV. STAT. § 743.006; 40 PA. CONS. STAT. ANN. § 751 (Purdon); R.I. GEN. LAWS § 27-31-8; S.C. CODE § 38-35-410; S.D. COMP. LAWS ANN. § 58-11-12; TENN. CODE ANN. § 56-26-102; TEX. INS. CODE art. 3.42; UTAH CODE ANN. § 31-19-9; VT. STAT. ANN. tit. 8, § 4481; VA. CODE §§ 38.1-342.1, 38.1-362.8; WASH. REV. CODE ANN. § 48.18.100; W.VA. CODE § 33-6-8; WIS. STAT. § 631.20; WYO. STAT. § 26-15-112.

[9] N.Y. INS. LAW § 255 (McKinney 1966). Most states grant to the commissioner of insurance the authority to review and approve Blue Shield subscriber contracts that is separate from the authority to approve accident and health policy forms. At least 41 states in addition to New York empower the commissioner to review and approve the subscriber contracts of Blue Shield plans: ALA. CODE § 27-21-2; ALASKA STAT. ANN. § 21.87.180; ARIZ. REV. STAT. ANN. 20.826; ARK. STAT. ANN. § 66-4908; COLO. REV. STAT. § 10-16-115; DEL. CODE ANN. tit. 18, § 6306; FLA. STAT. ANN. § 641.04(3)(c); GA. CODE ANN. § 56-1812; IDAHO CODE § 41-3417(6); IND. CODE ANN. § 27-8-5-1; IOWA CODE § 514.7; KAN. STAT. ANN. § 40-1806; KY. REV. STAT. ANN. § 304.32-160; ME. REV. STAT. ANN. tit. 24, § 2316; MD. ANN. CODE art. 48A, § 355(a)(3), 356; MASS. GEN. LAWS ANN. ch. 176A, § 6; MICH. COMP. LAWS ANN. § 550.1204(1) & (2); MINN.

2. *Utilization of the NYSCA's Peer Review Committee by ULL is Required by State Law*

A second critical component of Respondent's antitrust claim is that the procedures established by Petitioner NYSCA's peer review committee for interpreting the ULL policy language constitutes unlawful price fixing under the Sherman Act. Since these procedures generated the denial of insurance coverage for Respondent's services, they represent "conduct" at the heart of Respondent's antitrust claim. Like the language of the ULL insurance policy, however, the utilization of Petitioner NYSCA's peer review committee by ULL is conduct regulated by New York insurance law. The state of New York[10] and 36 other states[11] have provisions in their unfair

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(Footnote 9, cont'd)
STAT. § 62C.14; MISS. CODE ANN. § 83-41-109; MO. REV. STAT. § 354.085; MONT. REV. CODES ANN. § 33-30-301; NEB. REV. STAT. § 21-1512; NEV. REV. STAT. § 695B.230; N.H. REV. STAT. ANN. § 419:6; N.J. STAT. ANN. § 17:48-8; N.M. STAT. ANN. § 59-19-16; N.C. GEN. STAT. § 57-4; N.D. CENT. CODE § 26-26-08; OKLA. STAT. ANN. tit. 36, § 2606 (West); OR. REV. STAT. § 743.006; 40 PA. CONS. STAT. § 6329; S.D. COMP. LAWS ANN. § 58-40-10; TENN. CODE ANN. § 56-29-117; TEX. INS. CODE art. 20.02(e); UTAH CODE ANN. § 31-37-13; VT. STAT. ANN. tit. 8, § 4587; VA. CODE § 38.1-818; WASH. REV. CODE ANN. § 48.44.020; W. VA. CODE § 33-24-6(b); WIS. STAT. § 655.24; WYO. STAT. §§ 26-23-101; 26-15-112.

[10] N.Y. INS. LAWS § 40-d (McKinney Supp. 1981).

[11] ALA. CODE § 27-12-14; ALASKA STAT. ANN. § 21.36.125; ARK. STAT. ANN. § 66-3005; CAL. INS. CODE § 790.03 (West); COLO. REV. STAT. § 10-3-1104; CONN. GEN. STAT. ANN. § 38-61; DEL. CODE ANN. tit. 18, § 2304; FLA. STAT. ANN. 626.9541; GA. CODE ANN. § 56-317.1; HAWAII REV. STAT. § 431-647; IDAHO CODE § 41-1329; ILL. REV. STAT. ch. 73, § 1546; IOWA CODE § 507B.4; KAN. STAT. ANN. § 40-2404; MASS. GEN. LAWS ANN. ch. 176D, § 3; MICH. COMP. LAWS ANN. § 500.2026; MINN. STAT. § 72A.20; MO. REV. STAT. § 375.936; MONT. REV. CODES ANN. § 33-18-201; NEB. REV. STAT. § 44-1525; NEV. REV. STAT. § 686A.310; N.H. REV. STAT. ANN. §417:4; N.J. STAT. ANN. § 17:29B-4; N.M. STAT.

trade practice laws which govern unfair claim settlement practices. These laws are patterned after the NAIC's Model Unfair Trade Practices Act which, among other provisions, requires insurance companies to conduct "a reasonable investigation based upon all available information" before paying insurance claims.[12] Since the activities of the chiropractic peer review committee in this case clearly involve standards for the "investigation" of insurance claims involving chiropractic services, such procedures are "required" under the insurance laws of New York and most other states. Consequently, the activities of the chiropractic peer review committee involved here are exempt from antitrust challenge through the operation of section 2(b) of the McCarran Act.

It is interesting to note that neither the trial court nor the Second Circuit Court of Appeals discussed the impact of New York's unfair claims settlement law on the facts of this case. If, in fact, Mr. Pireno's patients believed they were not treated fairly by the NYSCA peer review committee they could have contacted the New York Insurance Department and requested an administrative review of the committee's activities. A finding by the New York Insurance Department that such activities constituted too restrictive claims review procedures could lead to the payment of a $500 fine for each of the claims of Mr. Pireno's

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(Footnote 11, cont'd)
ANN. § 59-11-13; N.C. GEN. STAT. § 58-54.4; N.D. CENT. CODE § 26-30-04; OKLA. STAT. ANN. tit. 36, § 1219 (West); OR. REV. STAT. § 746.230; 40 PA. CONS. STAT. ANN. § 1171.5 (Purdon); S.C. CODE § 38-55-70; TEX. INS. CODE ANN. art. 21.21, § 2; VT. STAT. ANN. tit. 8, § 4724; VA. CODE § 38.1 — 52.9; WASH. ADMIN. CODE § 284-30-330; W. VA. CODE § 33-11-4; WIS. ADM. CODE Ins. 6.11(3).

[12] NAIC Model Act Relating to Unfair Methods of Compensation and Unfair and Deceptive Act and Practices in the Business of Insurance § 4(9)(d), I NAIC PROCEEDINGS 493, 496 (1972).

patients that were reviewed by Petitioner NYSCA's peer review committee.[13] The NAIC raises this example of the operation of state insurance laws to highlight for the Court the fact that relief for Petitioners' alleged harmful conduct is available under state insurance laws without resorting to the federal antitrust laws.

III. THE CHALLENGED ACTIVITIES OF PETITIONERS IN THIS CASE DO NOT CONSTITUTE A "BOYCOTT".

The third prerequisite for finding Petitioners' conduct exempt from the antitrust laws pursuant to the McCarran-Ferguson Act is that such conduct must not constitute a boycott of Respondent's services. Although Respondent has not alleged that Petitioners' conduct constitutes a "boycott" of his services, this Court has established a strong presumption against exemptions from the antitrust laws. E.g., *Royal Drug Co., Inc. v. Group Life & Health Insurance Co.*, 440 U.S. at 231; *Abbot Laboratories v. Portland Retail Druggists Ass'n, Inc.*, 425 U.S. 1, 11 (1976); *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973). It is therefore important that the absence of a boycott be clearly established before this Court can refuse to permit Respondent's antitrust claim to proceed.

The term "boycott" in antitrust law has been defined as a "concerted refusal to deal." E.g., *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 212 (1957); *Times-Picayune Publishing Co. v. United States*, 354 U.S. 594, 625 (1953). Generally, the concept of boycott "refers to a method of pressuring a party with whom one has a dispute by withholding, or enlisting others to withhold, patronage or services from the target." *St. Paul Fire &*

[13] See N.Y. INS. LAW §§ 40-d, 5 (McKinney Supp. 1981).

Marine Insurance Co. v. Barry, 438 U.S. 531, 541 (1978). It implies two necessary elements: (1) concerted activity on the part of the accused party from which an implied conspiracy can be inferred, and (2) a refusal to deal with others.

Applying the foregoing analysis to Petitioners' conduct in this case, there is no evidence that Petitioner ULL or Petitioner NYSCA refused to deal with Respondent. Neither Petitioner ULL nor Petitioner NYSCA had any voice in the selection of Respondent's services by Respondent's patients; only after a patient decided to utilize Respondent's services did ULL or NYSCA have any relationship with Respondent. This set of circumstances is similar to the facts of the *Bartholomew* case noted above. In that case the Fourth Circuit refused to accept the allegation of the plaintiff chiropractors that the peer review committee's activities in that case constituted a "boycott" because the plaintiff's patients were free to choose their own doctor. *Bartholomew v. Virginia Chiropractor's Ass'n*, 612 F.2d at 817. Since ULL's insureds are free to select the chiropractor of their choice it is impossible for ULL or the NYSCA peer review committee to "refuse to deal" with Respondent within the meaning of the antitrust concept of a boycott.

Furthermore, it is important to note that Respondent Pireno has not been deprived of his full fees as a result of Petitioners' conduct. The district court below specifically found that Respondent's "usual practice is to request, and receive, payment from the patient at the time services are rendered." *Pireno v. New York State Chiropractic Ass'n*, [1979] 2 TRADE CASES (CCH) ¶ 62,758 at 78,375. As the district court in *Ratino* found, it is difficult to establish "concerted"

activity on the part of Petitioners if there is a conspicuous lack of intent on the part of Petitioners to deprive Respondent of his fees. *Ratino v. Medical Service of the District of Columbia,* [1981] 2 TRADE CASES (CCH) ¶ 62,758 at 76,861. Thus, Petitioners' conduct is hardly the type of "pressure" described by this Court in *St. Paul Fire & Marine v. Barry* as is necessary to establish a "boycott" under the federal antitrust laws. *See* 438 U.S. at 541. As a result, the Court should find that Petitioners' activities fit squarely within the McCarran Act exemption from the antitrust laws.

CONCLUSION

The NAIC believes that an insurer's use of a committee of licensed chiropractors to interpret insurance policy provisions limiting coverage to "reasonable" charges for chiropractic services fits within the McCarran-Ferguson antitrust exemption for activities that are the "business of insurance," "regulated by State law," and not a "boycott." The NAIC asks this Court to use the adjuster analysis as a supplement to the rationale of *Royal Drug* and include Petitioners' contested activities in the "business of insurance" definition. Furthermore, Petitioners' contested activities are subject to regulation by state laws that "proscribe, permit or authorize" the "regular, customary and reasonable" language in the ULL insurance contract and the use of the NYSCA peer review committee to interpret such language. Finally, Petitioners' contested activities are not a "boycott" within the meaning of the federal antitrust laws since there is no refusal to deal with Respondent. For these reasons, the NAIC urges this Court to deny Respondent the use of the federal antitrust laws in

his attempt to obtain higher prices for his chiropractic services by ruling that Petitioners' activities are exempt from antitrust liability.

Respectfully submitted this
30th day of December, 1981,

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Nos. 81-389 and 81-390

In the Supreme Court of the United States

OCTOBER TERM, 1981

UNION LABOR LIFE INSURANCE COMPANY, PETITIONER

v.

A. ALEXANDER PIRENO

NEW YORK STATE CHIROPRACTIC ASSOCIATION, PETITIONER

v.

A. ALEXANDER PIRENO

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether an alleged conspiracy to eliminate price competition among chiropractors through a peer review committee that advises an insurance company whether chiropractic services and charges to insured patients are reasonable and necessary is (a) part of the "business of insurance" and (b) regulated by state law within the meaning of the McCarran-Ferguson Act.

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UNION LABOR LIFE INSURANCE COMPANY, PETITIONER

v.

A. ALEXANDER PIRENO

No. 81-390

NEW YORK STATE CHIROPRACTIC ASSOCIATION, PETITIONER

v.

A. ALEXANDER PIRENO

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

The question presented in this case concerns the scope of the exemption from the antitrust laws afforded to the business of insurance by the McCarran-Ferguson Act, 15 U.S.C. 1011-1015. The United States has primary responsibility for enforcement of the antitrust laws. It therefore has a general interest in urging that statutes creating exemptions from the antitrust laws be interpreted to displace competition only to the extent intended by Congress. Interpretation of the McCarran-Ferguson Act is of particular importance to the United States because the scope of the exemption afforded to the insurance industry will affect its prosecutorial decisions. The United States has filed amicus curiae briefs in the two most recent cases in which this Court has considered the

scope of the antitrust exemption Congress created when it enacted the McCarran-Ferguson Act. See *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), and *St. Paul Fire & Marine Insurance Co.* v. *Barry*, 438 U.S. 531 (1978).

STATEMENT

1. Petitioner New York State Chiropractic Association ("NYSCA"), a professional association of chiropractors, operates a Peer Review Committee which, on request, reviews the chiropractic treatment provided and the fees charged particular patients to determine whether the treatment and charges are necessary and reasonable. The Committee is composed of practicing chiropractors who serve on a voluntary basis. It was established by NYSCA in order to "bring about more widespread coverage of chiropractic services by insurance companies and also to increase the number of claims allowed by companies who provided chiropractic coverage" (NYSCA Pet. 4).[1]

While review may be requested by a chiropractor or a patient, the NYSCA committee usually performs its peer review function at the request of an insurance company that believes a chiropractor's charge for treatment rendered to a policyholder may have been excessive or that the treatment may have been unnecessary (Pet. App. 4a). The Committee's opinion as to whether the chiropractor's treatment and charges are reasonable is not binding on any party absent prior stipulation (*ibid.*).

Petitioner Union Labor Life Insurance Company ("ULL") is an accident and health insurance company licensed and subject to regulation by the State of New York (ULL Pet. 2-3). ULL's health insurance policies limit coverage for medical treatment, including chiroprac-

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[1] "NYSCA Pet." refers to the petition in No. 81-390. "ULL Pet." refers to the petition in No. 81-389. "Pet. App." refers to the appendix to the petition in No. 81-389. "ULL Br." and "NYSCA Br." refer to the briefs on the merits filed by petitioners.

tic services, to " 'the reasonable charges * * * for necessary medical care and services' and the 'regular and customary charges for the services and treatment furnished' " (*id.* at 4). In deciding whether particular claims are within these limits, ULL sometimes requests a non-binding opinion from the NYSCA Peer Review Committee (Pet. App. 5a).[2]

Respondent A. Alexander Pireno is a chiropractor licensed and practicing in New York. On occasion, claims by his patients for reimbursement under ULL policies have been reviewed and found unreasonable by the NYSCA Peer Review Committee (Pet. App. 5a-6a & n.2).[3]

2. Respondent Pireno filed this action in the United States District Court for the Southern District of New York, alleging that the peer review practices of NYSCA and ULL violated Section 1 of the Sherman Act. He claimed that NYSCA, ULL and others had conspired to fix the prices chiropractors, including Pireno, charge for their services by refusing to reimburse patients for services or charges deemed unreasonable or unnecessary.[4] Pireno thus alleged that his patients were deprived of the benefits of competition in the acquisition of his services and of coverage to which they were entitled under ULL policies, and that he was restrained in making his chiropractic services available to the public. Pireno

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[2] ULL's insurance policies do not refer to the Committee or the practice of peer review. See J.A. 21a-26a.

[3] The number of times this has occurred is disputed (Pet. App. 25a).

[4] Amicus National Association of Insurance Commissioners ("NAIC") suggests (NAIC Br. 18-20) that the complaint also challenges as a violation of the antitrust laws ULL's use of the "usual, customary and reasonable" standard for limiting reimbursement. The courts below and the parties, however, have construed the complaint as challenging solely the peer review procedure, not the contractual standard used by ULL to limit its reimbursement obligation. Accordingly, we view the complaint as challenging only the peer review agreement between petitioners.

sought declaratory and injunctive relief against the practice of peer review (Pet. App. 6a; J.A. 4a-9a).[5]

3. After discovery, the district court granted the motion of NYSCA and ULL for summary judgment (Pet. App. 20a-37a). It noted that the McCarran-Ferguson Act exempts from the antitrust laws conduct that constitutes the business of insurance, is regulated by state law, and is not a boycott. And it found that the challenged peer review activity satisfied all the criteria for exemption under the Act. The peer review agreement was, in the court's view, the "business of insurance" because the Committee's recommendation was used by ULL in interpreting the scope of its contractual obligations to subscribers (*id.* at 30a). The conduct at issue was deemed to be "regulated by state law" because "New York has enacted a pervasive scheme of regulation and supervision of insurance," because state law prohibits unfair claims settlement by insurers, and because state antitrust law (New York's Donnelly Act) is applicable to insurers (*id.* at 31a, 32a). Finally, the court held that Pireno had neither alleged the existence of a "boycott" nor come forward with evidentiary support for such a claim (*id.* at 33a-36a).

4. A unanimous panel of the Second Circuit reversed. The court of appeals held that, under this Court's decision in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), " 'the underwriting or spreading of risk is a critical determinant in identifying insurance' " (Pet. App. 14a, quoting 440 U.S. at 213, 211). It found "neither risk transference nor risk spreading in the peer review process" (Pet. App. 14a). Rather, it viewed peer review as a procedure, available *after* risk has been transferred, that is designed to reduce the insurer's costs (*id.* at 15a-16a). Relying on this Court's

[5] Pireno sought no antitrust damages, but alleged that he had been libeled by opinion letters written by the Committee, and sought $1,000,000 in punitive damages on the libel claim (Pet. App. 6a). That claim was dismissed by the district court (*id.* at 36a-37a).

decision in *Royal Drug*, *supra*, the court rejected the notion that all agreements having any effect on the relationship between an insurer and an insured are part of the business of insurance. Such an interpretation, it observed, would create an exemption broader than that intended by Congress (*id.* at 17a-18a). Finally, the court noted that "the peer review committee is not a member of the insurance industry." Its activities therefore do not fall within the McCarran-Ferguson exemption, which "seeks primarily to shield agreements among insurers, not those between insurers and persons outside the industry" (*id.* at 18a, citing *Royal Drug*, *supra*, 440 U.S. at 221-222, 224-225 n.32).

Because it concluded that the peer review process was not part of the "business of insurance," the court of appeals did not decide whether the two other requirements for McCarran-Ferguson immunity—that the conduct at issue be regulated by state law, and that it not constitute a boycott, coercion, or intimidation—were satisfied. The court "observe[d], however, that defendant NYSCA itself does not appear to be regulated by state law in the manner § 2(b) requires" (Pet. App. 8a n.5).

SUMMARY OF ARGUMENT

1. There is no issue before this Court concerning the lawfulness of petitioners' agreements or practices under the antitrust laws. Although petitioners argue that peer review committees of the kind involved in this case serve a procompetitive purpose, those arguments are irrelevant in the present procedural posture of this case because the merits of the complaint have not yet been addressed by the lower courts.

As a general matter, however, the antitrust laws would not prohibit an insurer from seeking the expert advice of providers of chiropractic services concerning the reasonableness of particular claims. But the antitrust laws would prohibit the use of a peer review committee to restrict price competition among providers or to impose

other restraints of trade unnecessary to a procompetitive advisory function.

2. Under the principles announced by this Court in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 231 (1979), the conspiracy alleged in this case—an agreement between an insurer and a provider peer review committee that allegedly restrains competition in the provider market—does not fall within the McCarran-Ferguson Act exemption.

a. The agreement at issue does not satisfy any of the three interrelated criteria that have been used by this Court to determine whether a particular agreement is part of the "business of insurance." The peer review agreement itself plays no role in the underwriting or spreading of risk. It is not part of the contract between the insurer and the insured. Moreover, it involves parties wholly outside the insurance industry, and allegedly restrains competition in a provider market rather than an insurance market.

b. Even if the agreement at issue were part of the business of insurance, it would not be exempt from the antitrust laws. The McCarran-Ferguson Act expressly provides that the antitrust laws *are* applicable to the business of insurance "to the extent not regulated by state law." Consequently, the McCarran-Ferguson Act provides no immunity for unregulated private restraints. The laws of New York do not regulate insurer-provider peer review agreements, and the state law provisions relied on by petitioners do not satisfy the requirement that the particular practice at issue be regulated.

ARGUMENT

I. THIS COURT NEED NOT DECIDE WHETHER PEER REVIEW AGREEMENTS VIOLATE THE ANTITRUST LAWS

This case, in its present posture, does not require the Court to decide whether peer review procedures violate the antitrust laws. The only question is one of immunity from the antitrust laws, and if this Court should hold

that there is no immunity the lower courts would then be required to consider whether the practices are lawful. "It is axiomatic that conduct which is not exempt from the antitrust laws may nevertheless be perfectly legal." *Royal Drug, supra*, 440 U.S. at 210 n.5.

Petitioners and amici supporting them devote a substantial portion of their briefs to arguing that peer review is reasonable and beneficial to consumers and is an integral part of service benefit health plans (ULL Br. 28-30; NYSCA Br. 6-7). Conversely, respondent contends generally that peer review violates the antitrust laws because it constitutes "price fixing" and restrains trade in other ways (J.A. 6a-8a). These arguments, however important they may be in determining questions of substantive antitrust law, are irrelevant to the immunity issue.

As a general matter, however, antitrust principles would not forbid an insurer to seek the advice of experts, who are themselves providers of medical services, in order to determine whether particular charges or treatments are reasonable or necessary in a particular case and thus covered by an insurance policy.[9] For this reason, insurer-provider peer review agreements would raise antitrust concerns in only a limited set of circumstances in which the advisory function is abused. Nevertheless, because agreements of this sort have the potential to restrain competition, the particular agreement at issue should be subject to antitrust scrutiny. If the agreement does

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[9] Since peer review committees are only asked to determine whether a provider's fee is unreasonably high, the complaint appears to allege some type of maximum price fixing. The legality of the challenged conduct should be determined by economic analysis, rather than resort to conclusory labels. See Brief for the United States as Amicus Curiae in *State of Arizona* v. *Maricopa County Medical Society*, No. 80-419. If respondent is able to demonstrate that the challenged conduct does have the effect of a maximum price fixing agreement among competitors, petitioners should then be required to prove that their agreement is essential to productive activity which yields efficiencies and procompetitive benefits that outweigh the competitive dangers posed by horizontal maximum price fixing agreements. *Id.* at 23.

not restrain competition, the inquiry is at an end.[7] If there is some significant restraint, however, it is necessary to inquire further to determine whether that restraint is reasonably ancillary to a procompetitive purpose, and whether, on balance, the particular practice at issue is anticompetitive or procompetitive.[8] In short, a

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[7] Determining whether there is a restraint on competition will not always require a lengthy or complex proceeding. For this reason, we disagree with petitioner NYSCA's contention (NYSCA Br. 6) that the *possibility* of antitrust litigation will have an undue "chilling effect" on legitimate peer review activity. Meritless antitrust litigation can and should be disposed of without undue delay—through summary judgment when appropriate. See, *e.g.*, *Quality Auto Body, Inc.* v. *Allstate Insurance Co.*, 660 F.2d 1195, 1202 (7th Cir. 1981); *Sausalito Pharmacy, Inc.* v. *Blue Shield of California*, 1981-1 Trade Cas. (CCH) ¶ 63,885, at 75,607 (N.D. Cal. 1981); cf. *Medical Arts Pharmacy* v. *Blue Cross & Blue Shield*, 518 F. Supp. 1100 (D. Conn. 1981). See also *Reiter* v. *Sonotone Corp.*, 442 U.S. 330, 344-345 (1979).

[8] Since the issue of liability is not before the Court, we note only briefly some factors that are relevant in identifying situations requiring further competitive analysis. If a peer review committee were composed of persons representing a significant portion of the providers in the area or if the committee passed on a significant number of claims, its "advisory" opinions could have an anticompetitive potential. For example, such opinions could serve as "suggested prices" established by direct competitors. See *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975); *United States* v. *Nationwide Trailer Rental System, Inc.*, 156 F. Supp. 800, 805 (D. Kan.), aff'd, 355 U.S. 10 (1957); *Plymouth Dealers' Association* v. *United States*, 279 F.2d 128, 130, 134 (9th Cir. 1960). Conversely, if the committee reviewed only a small number of claims, it would not be likely to have an anticompetitive effect on provider prices. Peer review agreements also would raise antitrust concerns if the committee engaged in conduct aimed at disadvantaging certain competing providers by branding their services as unnecessary, even though they provided competent services at reasonable prices. Of course, an antitrust violation would exist if a committee operated explicitly as a cartel for providers, rather than as a source of impartial advice, and thus fixed rates at a non-competitive level. Factors such as these have been considered by the Department of Justice in evaluating peer review procedures. See business review letter from Donald I. Baker, Assistant Attorney General, Antitrust Division, to J. Brian Nieder-

peer review system challenged under the antitrust laws must be evaluated in terms of its economic purpose and effect.

At this preliminary stage, however, the Court is faced only with the threshold question whether an antitrust exemption shelters peer review agreements from all antitrust scrutiny. We turn to that question in the pages below.

II. THE ALLEGED CONSPIRACY BETWEEN PROVIDERS OF CHIROPRACTIC SERVICES AND AN INSURER TO FIX THE PRICES CHARGED FOR CHIROPRACTIC SERVICES IS NOT EXEMPT FROM THE ANTITRUST LAWS UNDER THE McCARRAN-FERGUSON ACT

Exemptions from the antitrust laws are to be construed narrowly and limited to the scope clearly intended by Congress. See, *e.g.*, *National Gerimedical Hospital and Gerontology Center* v. *Blue Cross of Kansas City*, No. 80-802 (June 15, 1981); *Abbott Laboratories* v. *Portland Retail Druggists Association*, 425 U.S. 1 (1976); *Connell Construction Co.* v. *Plumbers & Steamfitters*, 421

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hauser, Legal Director, International Chiropractor Association, March 2, 1977.

While these risks may be realized in some cases, it remains likely that peer review would serve a procompetitive purpose in most situations by fostering rational economic decisions that promote consumer welfare—the prime objective of the antitrust laws. See, *e.g.*, *National Society of Professional Engineers* v. *United States*, 435 U.S. 679 (1978); *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36 (1977); *Brunswick Corp.* v. *Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977). The fact that the peer review advisory function may have the practical effect of placing limitations on provider charges does not, by itself, mean that competition is unduly restrained. Nothing in the antitrust laws requires an insurer to offer compensation to providers that is unreasonably high, or to refrain from seeking expert advice that will assist it in controlling costs. And there is nothing inherently anticompetitive in a peer review committee's recommendation that an insurer not provide reimbursement for particular services that the committee finds to be unnecessary or unreasonably expensive.

U.S. 616 (1975); *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726 (1973). This general principle has been applied by this Court specifically to the McCarran-Ferguson Act. *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 231 (1979). As the Court stated in *Royal Drug*, "§ 2(b) of the Act does create a partial exemption from [the antitrust] laws. Perhaps more significantly, however, that section, and the Act as a whole, embody a legislative rejection of the concept that the insurance industry is outside the scope of the antitrust laws." 440 U.S. at 220.

The decisions of this Court establish that a party relying on the McCarran-Ferguson exemption must show (1) that the challenged conduct is the "business of insurance" (15 U.S.C. 1012(b)), (2) that the conduct is regulated by state law (*ibid.*), and (3) that the conduct does not constitute a boycott or coercion (15 U.S.C. 1013(b)). *Royal Drug, supra*, 440 U.S. at 210; *St. Paul Fire & Marine Insurance Co.* v. *Barry*, 438 U.S. 531, 539-540 (1978). Only the first two of these requirements are at issue in the present case.[9]

A. Peer Review Is Not Part of the Business of Insurance

The McCarran-Ferguson Act does not expressly define the term "business of insurance." *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 458 (1969). It is clear from the legislative history, however, that the term has a limited scope. Accordingly, the Act "does not exempt the business of insurance companies from the scope of the antitrust laws. The exemption is for the 'business of insurance,' not the 'business of insurers.'" *Royal Drug, supra*, 440 U.S. at 211.[10]

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[9] Respondent does not challenge the district court's holding that there was no boycott (see Pet. App. 33a-36a).

[10] Congress explicitly rejected various proposals that would have provided the insurance industry with blanket antitrust immunity. See H.R. 3270, 78th Cong., 1st Sess. (1943); S. 1362, 78th Cong., 1st Sess. (1943); see also *Royal Drug, supra*, 440 U.S. at 219. These

In determining the scope of the exemption, this Court has looked to the common meaning of the term "insurance" and to the legislative history of the Act, and has identified several interrelated criteria that are relevant in determining whether a particular agreement is part of the business of insurance: (1) whether the agreement underwrites or spreads risk; (2) whether it is part of the policy relationship between the insurer and the insured; and (3) whether it is limited to entities within the insurance industry. The alleged conspiratorial conduct challenged in this case does not satisfy any of these criteria.

1. Peer review does not underwrite or spead risk

This Court has recognized that "underwriting or spreading of risk" is an "indispensable characteristic of insurance." *Royal Drug*, *supra*, 440 U.S. at 212; *SEC* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 71 (1959); *German Alliance Insurance Co.* v. *Kansas*, 233 U.S. 389, 412 (1914). The legislative history of the Act is consistent with this interpretation.[11] As the Court noted in *Royal Drug* (440 U.S. at 221), the House Judiciary Committee Report on H.R. 3270, a forerunner of the McCarran-Ferguson Act, characterized insurance as the "distri-

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bills would have provided that nothing in the Sherman or Clayton Acts "shall be construed to apply to the business of insurance or to acts in the conduct of that business or in any wise to impair the regulation of that business by the several States." See also 90 Cong. Rec. 6565 (1944).

The bill providing for blanket immunity failed in the Conference Committee because of a fear that it could not pass in the Senate and in any event would be vetoed by the President. 91 Cong. Rec. 1087 (1945) (remarks of Rep. Hancock). The National Association of Insurance Commissioners also opposed a blanket antitrust exemption. 90 Cong. Rec. 8482 (1944). See *Royal Drug*, *supra*, 440 U.S. at 219 n.21; see also page 22, *infra*.

[11] See 90 Cong. Rec. 6544 (1944) (remarks of Rep. Clason); 90 Cong. Rec. 6526 (1944) (remarks of Rep. Hancock); H.R. Rep. No. 873, 78th Cong., 1st Sess. 8-9 (1943); S. Rep. No. 1112, 78th Cong., 2d Sess. 6 (1944).

bution of risk according to hazard, experience, and the laws of averages," factors that "are not within the control of insuring companies in the sense that the producer or manufacturer may control cost factors." H.R. Rep. No. 873, 78th Cong., 1st Sess. 8-9 (1943); see also S. Rep. No. 1112, 78th Cong., 2d Sess. 6 (1944) (insurance is a personal promise of indemnity, "quite different from the ordinary commercial transaction"). Thus, it was the transference and underwriting of risk that, in the view of Congress, distinguished the business of insurance from other commercial activities and justified a limited antitrust exemption.

In *Royal Drug*, this Court recognized that Blue Shield, through its contracts with subscribers, had assumed a major portion of the financial risk that its subscribers would need to purchase prescription drugs. The contracts between Blue Shield and participating pharmacies, which were at issue there, were means by which Blue Shield fulfilled this obligation and minimized the costs it incurred in doing so. 440 U.S. at 213-214. But the Court rejected the argument that these insurer-provider agreements themselves served to underwrite risk, explaining that: "The fallacy of the petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies * * * and the agreements between Blue Shield and the participating pharmacies." 440 U.S. at 213.

Petitioner ULL has likewise confused the obligations of the insurer "under its insurance policies" and the peer review agreement between the insurer and chiropractors. It argues (ULL Br. 17-18) that, because "peer review is a device which helps implement and make meaningful the underwriting, risk-spreading and risk transfer decisions reflected in the insurance policy," it "is an integral part of the underwriting process." But it is the insurance *policy*—not the peer review arrangement—that defines and implements the risk transfer. The insurer, through its contracts with policyholders, has assumed

(and spread) a major portion of the risk that policyholders will incur expenses for chiropractic services. The contracts provide that the insurer will pay "the reasonable charges * * * for necessary medical care and services" and "the regular and customary charges for the services and treatment furnished" (ULL Br. 4; J.A. 18a-19a, 21a-26a). The risk of unreasonable charges or charges for unnecessary services is thus retained by the policyholder.

Peer review itself plays no role in the underwriting or spreading of the risk of medical expenses, and the insurer's contractual obligation is not defined in terms of or altered by peer review. Petitioners readily concede that the committee's view is not binding on either party (ULL Br. 5; NYSCA Br. 4) and thus that the peer review committee has no authority to determine the scope of the risk assumed by the insurer under its contract with the policyholder. If the insurer and the policyholder disagree as to whether a claim falls within the risk transferred to the insurer, that dispute, like any other dispute about the meaning of an insurance contract, must be resolved by the courts or in an administrative adjudication provided by state law.

Rather than underwriting or spreading risk, the peer review agreement, like the *Royal Drug* provider contracts, is utilized only after risk has been allocated between insurer and insured.[12] Like an insurer-pharmacy agreement, a peer review agreement may aid the insurer in fulfilling its obligation to policyholders by helping the insurer to identify claims that are reasonable and there-

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[12] Amici American Insurance Association, *et al.* ("AIA") argue (AIA Br. 11-12) that where coverage is limited to "reasonable" or "customary" charges, the transfer of risk takes place not when the parties sign the insurance contract, but when a particular claim is settled. Such a view is at odds with the basic principle of insurance law that it is the policy that defines the scope of the risk assumed by the insurer (Pet. App. 14a-15a). Indeed, the sole purpose of the settlement process is to determine whether a subsequent occurrence or claim falls within the scope of the risk previously assumed by the insurer under the policy (*id.* at 15a).

fore should be paid. And, again like an insurer-pharmacy agreement, a peer review agreement also may minimize the insurer's costs.[13] But because it does not allocate or spread the risk covered by the insurance policy, peer review, like "countless other business arrangements that may be made by insurance companies" to assist in carrying out their obligations and reducing costs (*Royal Drug, supra*, 440 U.S. at 215), does not have the essential characteristic of the business of insurance.[14]

2. Peer review is not part of the contract between the insurer and the insured

This Court has recognized that "[a]nother commonly understood aspect of the business of insurance relates to the contract between the insurer and the insured" (*Royal Drug, supra*, 440 U.S. at 215), and that "whatever the exact scope of the statutory term [business of insurance], it is clear where the focus was—it was on the relationship between the insurance company and the policyholder" (*SEC* v. *National Securities, Inc., supra*, 393 U.S. at 460).

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[13] Peer review may provide expertise that otherwise would be difficult or expensive for the insurer to obtain and may help the insurer avoid paying claims which, because they are unreasonable, are not within the scope of its policies.

[14] Petitioner ULL argues (ULL Br. 18-19) that the fact that conduct reduces insurer costs does not by itself place the conduct outside of the "business of insurance." We agree. The holding of *Royal Drug*, however, is that a cost reduction effect does not in itself bring an agreement *within* the business of insurance. If a policy provision reduces insurer costs by limiting the risk assumed by the insurer, it allocates the risk at issue and constitutes the business of insurance. Petitioner (ULL Br. 18-19) lists cost-reducing policy provisions such as "coverage deductibles, underwriting exclusions, co-insurance factors and risk limitations" as constituting part of the business of insurance. It is instructive to note, however, that all of those provisions are means by which the parties to the insurance contract expressly allocate risk. In contrast, the peer review agreement challenged here neither allocates risk by itself nor constitutes part of the contractual agreement between insurer and insured.

The provider agreements in *Royal Drug* were not the business of insurance because they were "not 'between insurer and insured' [but were] separate contractual arrangements between Blue Shield and pharmacies engaged in the sale and distribution of goods and services other than insurance." 440 U.S. at 216. Similarly, peer review is not a part of ULL's contracts with its policyholders. As petitioners concede, there is no mention of peer review in ULL's contracts with its subscribers; the agreement at issue is a separate arrangement between the insurer and the providers.

Petitioners' argument (ULL Br. 16; NYSCA Br. 6) that peer review is entitled to McCarran-Ferguson antitrust immunity because it "directly involves the 'interpretation' and 'enforcement' of the insurance contract" confuses the agreement between insurer and insured with the agreement between the insurer and a peer review committee. It is the latter that is the gravamen of the alleged antitrust violation, not the former. The complaint does not claim that ULL's "interpretation or enforcement" of the insurance policy violates the antitrust laws (see note 4, *supra*). Rather, it alleges that the consulting arrangement between the insurer and providers has the effect of fixing chiropractor fees. The consulting arrangement does not "interpret or enforce" the insurance contract. Those tasks are performed initially by the insurer and, in case of disagreement between the insurer and the policyholder, by the courts or state insurance authorities.[15]

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[15] Amici American Insurance Association, *et al.* (AIA Br. 12) attempt to distinguish *Royal Drug* by arguing that the pharmacy-insurer agreements in that case had no effect on costs to the insureds while the insurer-provider agreement at issue here does affect the policyholders' costs because it influences the determination whether a claim will be honored. This argument is wrong for two reasons. First, the insurer-pharmacy agreements in *Royal Drug* did have an impact on costs to the insureds. The insurer generally would pay a larger percentage of the insureds' drug expenses if they went to a participating pharmacist (440 U.S. at 209 and n.3). Thus, the

Insurer consultation with a peer review committee is but one of several means by which the insurer can reach its initial determination on the issue of coverage. Certainly, the provider-consulting agreement challenged here may affect the insureds' choice of providers and the insurer's costs. But such an indirect connection does not bring the insurer-provider agreement within the business of insurance. *Royal Drug, supra*, 440 U.S. at 216-217 & n. 14. As the Court noted, the argument that an impact on a contract of insurance would be sufficient to make an insurer's agreement with providers the "business of insurance" would "prov[e] too much." 440 U.S. at 216. "[E]very business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer." 440 U.S. at 216-217. Thus, to include in the "business of insurance" all agreements to which an insurer is a party would be "plainly contrary to the statutory language, which exempts the 'business of insurance' and not the 'business of insurance companies.'" 440 U.S. at 217.

Moreover, the consultation agreement here at issue is, in a significant respect, not even as closely related to the contract between the insurer and the insured as were the provider agreements in *Royal Drug*. In that case, both the majority and the dissenting opinions noted (440 U.S. at 213 n. 9, 246-247) that the challenged agreements between the insurer and the providers were necessary for a service benefit plan to exist—*i.e.*, the insurance policy

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cost and convenience of the insureds in *Royal Drug* were affected by the insurer's ability to enter into agreements with many pharmacists. Second, the provider-insurer consulting arrangement at issue here does not directly affect subscriber costs. To be sure, the ultimate determination whether a claim is covered certainly will affect the subscribers' costs; but as indicated above, the consulting agreement merely assists the insurer in carrying out its role in the settlement or adjustment of the claim. The provider committee's advice is not called for by the insurance contract, is not necessary to its implementation, and is not in any event a binding determination.

contemplated that the insurer would enter into agreements with pharmacies. Indeed, the dissent asserted that the pharmacy agreements constituted the business of insurance because "some form of provider agreement is necessary to fulfill the obligations of a service-benefit policy." 440 U.S. at 252. Here, in contrast, the insurer has no obligation to provide peer review to its policyholders, and the peer review system is not necessary to carry out the insurer's obligation to provide reimbursement for reasonable and necessary medical expenses. In fact, most payment decisions are made by the insurer on the basis of its own experience without ever consulting the peer review committee, and even petitioner concedes that there are other means by which the insurer may obtain expert advice to assist it in resolving particular claims (ULL Br. 4, 28-29).

3. The challenged conduct involves parties wholly outside the insurance industry and allegedly restrains competition in a provider market rather than an insurance market

A third factor considered by this Court in *Royal Drug* in determining whether conduct falls within the McCarran-Ferguson exemption is the extent to which the agreement at issue involves non-insurance entities and allegedly restrains competition outside of the insurance industry. In particular, the Court emphasized that a narrow construction of the "business of insurance" is "appropriate * * * [where] the * * * [a]greements involve parties wholly outside the insurance industry." 440 U.S. at 231. And while the dissenting Justices in *Royal Drug* were unwilling to find *all* provider agreements non-exempt, they too identified provider involvement as a factor to be considered in determining whether an agreement is part of the business of insurance. Accordingly, they emphasized that "[a]n insurance company cannot immunize an illegal conspiracy by joining it." 440 U.S. at 253 (Brennan, J., dissenting).

Attention to the nature and extent of provider involvement in the agreement at issue also is required by the language and legislative history of the Act. The primary purpose of the Act was to preserve traditional state regulation and taxation of insurance. *Royal Drug, supra*, 440 U.S. at 218 n. 18. In addition, Congress sought to shield from possible antitrust liability collective ratemaking activities of *insurers* that were required or approved by state regulatory authorities. "Because of the widespread view that it is very difficult to underwrite risks in an informed and responsible way without *intra*-industry cooperation, the primary concern of both representatives of the insurance industry and the Congress was that cooperative ratemaking efforts be exempt from the antitrust laws." *Royal Drug, supra*, 440 U.S. at 221 (emphasis added). The National Association of Insurance Commissioners' legislative proposal,[16] for example, pointed to the need of insurers for "*combined efforts for statistical and rate-making purposes*," and noted that "Congress itself recently recognized *the necessity for concert of action in the collection of statistical data and rate making* when it enacted the District of Columbia Fire Insurance Rating Act." 90 Cong. Rec. A4405 (1944) (emphasis added).

In view of this background, it is not surprising that the language and legislative history of the Act reflect no congressional purpose to displace competition in other industries by immunizing agreements involving entities outside the business of insurance that restrict competition in other markets. "Each of the specific practices [which the NAIC proposed to immunize] involved intra-industry cooperative or concerted activities. None involved contractual arrangements that insurance companies might make with providers of goods or services." *Royal*

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[16] 90 Cong. Rec. A4403-A4408 (1944), quoted in *Royal Drug, supra*, 440 U.S. at 221-222. "The views of the NAIC are particularly significant, because the Act ultimately passed was based in large part on the NAIC bill." *Royal Drug, supra*, 440 U.S. at 221, citing 91 Cong. Rec. 483 (1945) (remarks of Sen. O'Mahoney).

Drug, supra, 440 U.S. at 222.[17] And none involved agreements to restrain competition among providers of services to insured patients. See 90 Cong. Rec. A4406 (1944).[18]

The economic rationale for distinguishing agreements involving providers from those involving only insurers and their subscribers is particularly compelling when there is a horizontal combination of providers. Such an agreement has the potential to restrain competition among providers—a result at odds with fundamental Sherman Act principles that Congress had no intent to displace.

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[17] The reliance of petitioner ULL (ULL Br. 24, n.22) and amici Health Insurance Association of America *et al.* ("HIAA") (HIAA Br. 17) on the NAIC proposals is misplaced. The proposals cited would have exempted from the antitrust laws collective adjustment activities by insurance companies. But that type of intra-industry horizontal activity is not at issue here, and there is no suggestion that the NAIC proposals would have exempted agreements among providers.

Petitioner's (ULL Br. 20-25) and amici's (AIA Br. 8-19; NAIC Br. 12-16; HIAA Br. 18-19) efforts to analogize peer review to an insurance company's relationship with independent adjusters misses a critical distinction. Even if, as they suggest, Congress had intended to encompass the relationship between an insurer and an independent adjuster within the term "business of insurance," that purpose would not extend to peer review activities of providers of medical service. Although an adjuster may be independent in the sense of not being part of an insurance company, almost all, if not all, of an adjuster's business is related to the insurance industry. Thus, any restraint on competition arising from an insurer-adjuster agreement affects only the insurance industry. That is not true in the present case, where the competitive restraint allegedly falls on competition in the chiropractic services market. Accordingly, this case does not raise the question whether claims adjustment falls within the scope of the McCarran-Ferguson Act exemption.

[18] As noted by amici HIAA (Br. 5), the use of provider peer review in the health insurance field did not become common until the 1960s. The Court should be reluctant to impute to Congress an intent to exempt a provider practice that was not part of the "business of insurance" when the Act was passed.

Thus, the dissenting opinion in *Royal Drug* emphasized that the case before the Court did not involve allegations of conspiracy among providers. 440 U.S. at 253. By contrast, this case is in fact predicated on allegations of horizontal conspiracy among chiropractors.[19] In view of this Court's traditional reluctance to extend antitrust exemptions beyond the economic area that Congress clearly intended to immunize,[20] the allegation of chiropractor price fixing in this case is sufficient to require scrutiny under the Sherman Act.

B. Peer Review Is Not Regulated by State Law

Section 2(b) of the McCarran-Ferguson Act provides that the Sherman, Clayton and Federal Trade Commission Acts *are* applicable to the business of insurance "to the extent that such business is not regulated by State law." 15 U.S.C. 1012(b). Thus, proof that the conduct at issue is regulated by state law is an additional element

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[19] Amici argue (AIA Br. 18-19; HIAA Br. 21) that the chiropractors who perform peer review are functioning as insurers rather than providers. But it is clear that they are not insurers, for they are not employees of any insurance company, and the committee has not itself assumed any risk. In fact, the chiropractors are providers; insurers purchase their services indirectly by reimbursing policyholders.

[20] In *Royal Drug, supra*, 440 U.S. at 231-232, this Court viewed the case before it as similar to other cases in which an industry or group that has been granted an antitrust exemption for some of its activities nevertheless remains subject to the antitrust laws when it attempts to restrain competition outside of the area which is the focus of the statutory exemption. For example, an agreement between an exempt agricultural cooperative and a nonexempt entity is not within the antitrust exemption provided by the Capper-Volstead Act (*Case-Swayne Co.* v. *Sunkist Growers, Inc.*, 389 U.S. 384 (1967); *United States* v. *Borden Co.*, 308 U.S. 188 (1939)), nor is a labor union's agreement with one set of employers to impose a wage scale on other bargaining units immune from the antitrust laws (*Ramsey* v. *Mine Workers*, 401 U.S. 302, 313 (1971); *Mine Workers* v. *Pennington*, 381 U.S. 657, 665-666 (1965)).

essential to a McCarran-Ferguson Act defense.[21] Since the State of New York does not regulate the peer review activities that are the subject of respondent's antitrust complaint, this lack of regulation is an alternative ground on which the court of appeals' decision should be affirmed.[22]

1. The McCarran-Ferguson Act does not provide antitrust immunity for unregulated private conduct

The Section 2(b) proviso[23] imposes a significant limitation on the antitrust immunity afforded the business of insurance. Moreover, the legislative history plainly demonstrates that while Congress intended to preserve the power of the states to tax and regulate insurance, it did not intend to confer antitrust immunity on any unregulated private conduct.

In response to concerns raised by this Court's decision in *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944), the McCarran-Ferguson Act sought to reaffirm that the states are empowered to tax and regulate insurance.[24] To that end, the Act expressly

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[21] Of course, the fact that conduct is regulated under state insurance law does not make it the "business of insurance." See *Royal Drug, supra*, 440 U.S. at 230 n.38; *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969).

[22] The district court held that the conduct at issue was regulated by state law. The court of appeals did not reach this issue since it found that the conduct was not the business of insurance. It observed, however, that NYSCA itself was not regulated by state law. Because the state regulation issue has been argued by both sides here, however, this Court should reach the issue if necessary to the disposition of the case. *Dandridge* v. *Williams*, 397 U.S. 471, 475 n.6 (1970); see *Piper Aircraft Co.* v. *Reyno*, Nos. 80-848, 80-883 (Dec. 8, 1981), slip op. 10 n.12.

[23] "* * * the Sherman Act * * * the Clayton Act, and * * * the Federal Trade Commission Act * * * shall be applicable to the business of insurance to the extent that such business is not regulated by State law."

[24] *Royal Drug, supra*, 440 U.S. at 217-218 & nn. 16, 18; *St. Paul Fire & Marine Insurance Co.* v. *Barry, supra*, 438 U.S. at 539; S. Rep. No. 20, 79th Cong., 1st Sess. 2 (1945); H.R. Rep. No. 143, 79th Cong., 1st Sess. 2-3 (1945).

declared Congress' policy favoring state regulation and taxation of the business of insurance (15 U.S.C. 1011), and provided that the "business of insurance * * * shall be subject to the laws of the several States which relate to the regulation or taxation of such business" (15 U.S.C. 1012(a)). In addition, to avoid possible preemption of state insurance regulation by federal laws of general applicability, the Act provided that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance" (15 U.S.C. 1012(b)).

Congress also sought to reach an appropriate accommodation between the federal antitrust laws and state regulatory laws. While the House initially passed a bill that would have provided a complete antitrust exemption for the insurance industry,[25] the idea that insurers should enjoy antitrust immunity for unregulated activity met with substantial opposition,[26] and the bill never passed the Senate. Legislative action the following year demonstrates that Congress resolved the issue by limiting the McCarran-Ferguson antitrust exemption to state-regulated insurance activity.

Thus, the Senate Judiciary Committee reported a bill (S. 340, 79th Cong., 1st Sess. (1945)), providing a two-year moratorium period "[f]or the purpose of enabling adjustments to be made and legislation to be adopted by the several states and Congress" (Sec. 4(a)). During that period, while states were bringing their regulatory laws into compliance with the antitrust laws, the Sherman and Clayton Acts were not to be applicable "to the business of insurance, or to acts in the conduct of such business" (Section 4(a)). But because of concern with abuses of economic power, the Sherman Act would remain

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[25] See note 10, *supra*.

[26] See note 10, *supra*.

applicable to "any act of boycott, coercion, or intimidation" (Section 4(b)). The Senate Report emphasized that "this bill * * * does not repeal the Sherman and Clayton Acts," and that its purpose, in addition to permitting "continued *regulation*" by the states, was "to assure a *more adequate* regulation of this business in the States." [27]

When the bill reached the Senate floor, several Senators expressed concern that, as drafted, the bill appeared to allow the states to "repeal the Sherman Act" after the moratorium period. 91 Cong. Rec. 478-488 (1945). But that was not the Senate's intent. Rather, as Senator Ferguson stated: "We wanted to have the Clayton Act and the Sherman Act apply to insurance" after the moratorium period. 91 Cong. Rec. 486 (1945). The purpose of the moratorium, in the Senate's view, was only to allow the states to adjust their laws to avoid conflict with the Sherman Act—not to allow them to immunize private anticompetitive conduct. 91 Cong. Rec. 478-488 (1945). To eliminate any doubt about the subsequent applicability of federal antitrust laws to insurance, Senator Ferguson proposed, and the Senate adopted, an amendment making clear that the Sherman and Clayton Act *would* preempt inconsistent state legislation.[28]

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[27] S. Rep. No. 20, 79th Cong., 1st Sess. 2 (1945). The House Report (H.R. Rep. No. 143, 79th Cong., 1st Sess. 2 (1945)) further emphasized that while Congress was seeking to protect state power to tax and regulate insurance, "[n]othing in this bill is to be so construed as indicating it to be the intent or desire of Congress to require or encourage the several States to enact legislation that would make it compulsory for any insurance company to become a member of rating bureaus or charge uniform rates. It is the opinion of Congress that competitive rates on a sound financial basis are in the public interest."

[28] As amended (amendment underlined), Section 2(b) read:

> "No act of Congress *except the act of July 2, 1890, as amended, known as the Sherman Act, and/or the act of October 15, 1914, as amended, known as the Clayton Act,* shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of in-

The bill passed by the House [29] was essentially the same as the original version of S. 340, and the House Report on the bill [30] explained its purpose in language identical to that used in the Senate Report.[31] The issue of the application of the antitrust laws to the business of insurance after the moratorium period, however, was not addressed in the House bill because no agreement could be reached.[32]

The Section 2(b) proviso, which did not appear in either the House or Senate bill and which is not discussed in the Conference Report, appears to have been a compromise between the two houses on the role of state regulation in relation to the federal antitrust laws.[33] Under Section 3(b), boycotts, coercion and intimidation were not to escape the proscriptions of the Sherman Act under any circumstances. Under Section 2, however, the states were allowed to regulate other forms of collective insurance activity, and, to the extent that they exercised that option, federal antitrust laws were displaced. But if a state did not choose to regulate a potentially anticompetitive insurance activity to protect the public against abuse of economic power, federal antitrust law would apply. Thus, as the legislative history makes clear, conduct constituting the business of insurance was to be subject either to the federal antitrust laws or to state regu-

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surance, or which imposes a fee or tax upon such business, unless such act specifically so provides."

91 Cong. Rec. 486 (1945).

[29] S. 340 was amended in the House to substitute the text of a bill that had been introduced as H.R. 1973, 79th Cong., 1st Sess. (1945). See 91 Cong. Rec. 1085 (1945).

[30] H.R. Rep. No. 143, 79th Cong., 1st Sess. 2-3 (1945).

[31] See pages 22-23 & note 27, *supra*.

[32] See 91 Cong. Rec. 1087 (1945) (remarks of Rep. Hancock).

[33] See *St. Paul Fire & Marine Insurance Co.* v. *Barry*, *supra*, 438 U.S. at 547-548; 91 Cong. Rec. 1478 (Sens. McCarran and Pepper), 1480-1481 (Sens. Ferguson and Murdock), 1484 (Sen. Murdock) (1945).

lation and supervision. There were to be no loopholes for private restraints.[34]

Accordingly, the relevant inquiry under the "state regulation" requirement is whether the state has regulated the particular practice at issue. If it has not done so, application of the federal antitrust laws is fully consistent with the intent of the Congress, for it would not interfere with state regulation or expose the insurer to conflicting requirements under state and federal law. See generally *St. Paul Fire & Marine Insurance Co.* v. *Barry, supra*, 438 U.S. at 553-555. On the other hand, failure to apply the federal antitrust laws to private conduct not regulated by the state would frustrate Congressional intent by allowing private combinations to operate without regard to either the fundamental competitive policies of the antitrust laws or the alternative policies of state regulatory enactments. Moreover, such an extensive exemption would be at odds with this Court's admonition that "antitrust repeals are especially disfavored where the antitrust implications of a business decision"—such as the insurer's decision to use peer review—"have not been considered by a governmental entity." *National Gerimedical Hospital and Gerontology Center* v. *Blue Cross of Kansas City, supra*, slip op. 12.

2. New York State's regulation of insurance does not extend to peer review

Petitioners make no claim that application of the federal antitrust laws to peer review would "invalidate, impair or supersede" any law enacted by New York. Nor could it do so, for the alleged agreement to fix chiropractor fees through the use of peer review, which is the gravamen of respondent's complaint, was neither required

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[34] See *St. Paul* v. *Barry, supra*, 438 U.S. at 548-549. See also, e.g., 91 Cong. Rec. 1442-1444, 1480, 1483, 1486 (1945) (debate on Conference Report on S. 340); S. Rep. No. 20, 79th Cong., 1st Sess. 2 (1945); H.R. Rep. No. 143, 79th Cong., 1st Sess. 3 (1945). See generally, Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 Duke L.J. 587 (1978).

nor authorized by New York law. Thus, "the conduct with which petitioners are charged appears to have occurred outside of any regulatory or cooperative arrangement established by the laws of [the state]." *St. Paul* v. *Barry*, *supra*, 438 U.S. at 553-554.

Despite this lack of state supervision of the conduct at issue, petitioner asserts that the requisite state regulation exists because the State of New York has a "pervasive" and "comprehensive" scheme of insurance regulation (ULL Br. 31-33). More specifically, they contend that peer review is "regulated" because New York insurance law prohibits unfair claims practices and provides for administrative enforcement of that prohibition (*id.* at 31-32). They rely also on the fact that state law requires both that policy forms be approved by the state superintendent of insurance and that insurance be provided at reasonable rates (*id.* at 32). Finally, they argue that New York's state antitrust law, the Donnelly Act, which is applicable to insurers, also constitutes a form of state regulation sufficient under the McCarran-Ferguson Act (*id.* at 33). On examination, however, it is evident that none of these provisions of New York law amounts to state regulation of peer review procedures.[35]

a. First, the existence of a "comprehensive" or "pervasive" scheme of state regulation of insurance is not sufficient to confer immunity under the Act unless that scheme in fact regulates the particular practice at issue. As we have shown (see pages 20-25, *supra*), the statutory language makes the exemption available only "to the extent" that state regulation governs. Unless the specific activity challenged is regulated, Congress' desire to avoid private restraints—*i.e.*, to subject all insurance practices either to the federal antitrust laws or to state supervision

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[35] We do not understand the complaint to challenge ULL's policy terms or the insurer's decision not to pay certain claims (see note 4, *supra*). Thus, whether these provisions and practices are subject to state regulation within the meaning of the Act is irrelevant in this case.

(see pages 24-25, *supra*)—will be frustrated.[36] This Court, therefore, has looked to whether there is state regulation of a particular practice rather than of insurance generally. Thus, in *FTC* v. *National Casualty Co.*, 357 U.S. 560 (1958), the Court held that the FTC lacked authority "to regulate respondents' advertising practices in those States which are regulating *those practices* under their own laws." 357 U.S. at 563 (emphasis added).[37] See also *Owens* v. *Aetna Life & Casualty Co.*, 654 F.2d 218, 245-246 (Sloviter, J., dissenting) (3d Cir. 1981).[38]

b. Second, the specific provisions of the New York insurance law relied on by petitioners were not intended and are not used by the state as a means to regulate the

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[36] See Weller, *supra*, 1978 Duke L.J. 587, 606-619; Sullivan & Wiley, *Recent Antitrust Developments: Defining the Scope of Exemptions, Expanding Coverage, and Refining the Rule of Reason*, 27 U.C.L.A. L. Rev. 265, 288-291 (1979).

[37] The requirement that a state must regulate the particular conduct at issue in order to bring it within the exemption does not require the courts to determine whether the state's regulatory power is effectively exercised. Thus, our submission is not inconsistent with this Court's rejection of the argument in *FTC* v. *National Casualty Co.*, *supra*, that the exemption is unavailable merely because the state has not exercised its regulatory authority.

[38] Several courts of appeals also have recognized the relevance of regulation covering the specific practice at issue. See, *e.g.*, *Owens* v. *Aetna Life & Casualty Co.*, 654 F.2d 218, 225-226 (3d Cir. 1981); *Ohio AFL-CIO* v. *Insurance Rating Board*, 451 F.2d 1178, 1182 (6th Cir. 1971) ("Crucial to the present case is the fact that the Ohio statutes have specifically provided for the regulation of rating organizations such as [defendant], and the making, filing and use of rates for casualty insurance, including motor vehicle insurance"). On the other hand, some lower courts have indicated that the existence of a state insurance regulatory scheme is all that is required to satisfy the requirement of state regulation (See ULL Br. 33). For the reasons indicated above, these latter decisions fail correctly to analyze the statutory language and Congressional intent. We submit that Judge Slov[illegible]s dissent in *Owens* v. *Aetna Life & Casualty Co.*, *supra*, 654 F.2d at 245-246, presents the better analysis of the state regulation issue. See also Sullivan & Wiley, *supra*, 27 U.C.L.A. L. Rev. at 288-291.

insurer-provider agreements here at issue. The state's statutory prohibition of unfair claims settlement procedures[39] and its provision for administrative sanctions against insurers who engage in such practices[40] do not constitute regulation of peer review. Their purpose is narrow and specific: to ensure that insurers carry out their obligations to policyholders under contracts the state has approved and to require that insurers deal fairly with policyholders.[41]

Petitioners' related argument—that peer review is regulated by the state because it aids the insurer in fulfilling its obligation to settle claims fairly—also is without merit. Peer review is only one of many methods the insurer might use for that purpose, and it is neither required nor supervised by state law.[42] Accordingly, subjecting peer review to scrutiny under the federal antitrust laws would not interfere with state regulation.

Similarly, the state law requirement that ULL's policy forms be filed with and approved by the Superintendent of Insurance does not constitute regulation of the peer review practices here at issue. Peer review is not mentioned in ULL's policy. Moreover, so far as the record reveals, the state has made no analysis of peer review in the course of reviewing ULL's rate filings. Regulation of policy terms furthers the state's interest in supervising the contractual obligations and rights of insurers and

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[39] N.Y. Ins. Law §§ 40-d, 273 (McKinney 1966 & 1980-1981 Cum. Supp.).

[40] N.Y. Ins. Law §§ 276, 278 (McKinney 1966).

[41] See 11 New York, Codes, Rules and Regulations, Part 216 (1962). These regulations contain considerable detail concerning insurers' obligations in settling claims; they contain no mention of peer review.

[42] By contrast, New York's insurance law and regulations do provide for adjustment of health insurance claims by licensed adjusters (N.Y. Ins. Law § 123 (McKinney 1966 & 1980-1981 Cum. Supp.); 11 New York, Codes, Rules and Regulations, Part 26 (1962)) and by employees of insurance companies (N.Y. Ins. Law § 123(6)(a), (7) (McKinney 1966)).

policyholders. But such regulation evidences neither state supervision of, nor even state interest in, consultation agreements between an insurer and providers of health services.[43]

More fundamentally, the New York insurance law controls only insurance and insurers. It does not address competition in other markets, and it gives the Superintendent of Insurance no authority with respect to possible anticompetitive effects of insurer-provider agreements in *provider* markets.

c. Finally, the state antitrust law, applicable to all businesses in the state, including insurance companies, does not constitute "regulation" as required by the McCarran-Ferguson Act.[44] State antitrust laws do not, as a general matter, preempt federal antitrust law. Rather, both may be enforced since their purposes are harmonious. A special rule giving a state antitrust law preemptive effect where insurance is involved would be at odds with the language and legislative history of the Act.[45]

The language of the Act makes clear that Congress' concern was with a particular category of state law—statutes enacted by states "for the *purpose of regulating* the business of insurance, or which impose a fee or tax upon such business" (15 U.S.C. 1012(b)). The exemption does not extend to all laws *applicable to* the business of insurance. If it did, insurance companies could claim immunity simply because they are subject to any state law of general applicability.

Moreover, the proposition that state antitrust laws would not displace federal antitrust laws was specifically

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[43] See generally *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579, 584-585, 593-598 (1976).

[44] See Weller, *supra*, 1978 Duke L.J. at 634.

[45] See generally Weller, *To Preempt or To Accommodate: The Question of State and Federal Antitrust Laws Under the McCarran-Ferguson Act*, 9 Tol. L. Rev. 421 (1978).

addressed and confirmed during the final Senate debate on Section 2(b):

> Mr. PEPPER. Am I correct in saying that under the proviso which the Senator has just read, if a State made it an offense, under the laws of the State, to engage in combinations in restraint of trade, the Sherman Antitrust Act could not apply to combinations and restraints of trade by companies engaged in business in that State? Is not that what it means?
>
> Mr. O'MAHONEY. No * * *.[46]

The legislative history also supports the conclusion that the expression "regulated by state law" focuses exclusively on administrative regulation. Although many states had antitrust laws at the time the Act was passed, there is no indication that Congress viewed those laws as "regulation"[47] of insurance. Rather, the Congressional concern was that state insurance regulators be able to approve and supervise certain conduct that might otherwise violate the federal antitrust laws. The Senate debate on the Section 2(b) proviso emphasized repeatedly that not just any *legislation*, but only *regulatory* legislation, would make the federal antitrust laws inapplicable.[48]

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[46] 91 Cong. Rec. 1444 (1945).

[47] See Weller, *supra*, 9 Tol. L. Rev. at 431-434. State antitrust laws usually are prohibitory statutes enforced by the state attorneys general or private plaintiffs in the courts. Such law enforcement activity is usually not thought of as "regulation," but rather as a means of preserving a competitive economic system.

[48] In *St. Paul* v. *Barry*, *supra*, 438 U.S. at 549 (emphasis added by the Court), this Court quoted Senator O'Mahoney's comment:

> "I saw no objection to combinations or agreements among the [insurance] companies in the public interest *provided those combinations and agreements were in the open and approved by law. Public supervision of agreements is essential.*

In addition, the following comments by Senator McCarran support our analysis (91 Cong. Rec. 1443 (1945) (emphasis added)):

> "During the 3-year moratorium the States may, if they see fit to do so, enact legislation *for the purpose of regulation.* If they

This Congressional insistence that there be administrative supervision whenever the antitrust laws are displaced makes it clear that a state antitrust law is not "regulation" of the business of insurance within the meaning of the Act.[49]

Finally, state antitrust laws are not legislation enacted "for the purpose of regulating the business of insurance." See *SEC* v. *National Securities, Inc.*, *supra*, 393 U.S. at 460 ("Congress was concerned with the type of state regulation that *centers around* the contract of insur-

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do enact such legislation, *to the extent that they regulate* they will have taken the business of insurance in the respective States out from under the Sherman Antitrust Act, the Clayton Act, and the other acts. *If during the moratorium the States do not enact legislation for regulatory purposes, then on January 1, 1948, the Sherman Act, the Clayton Act, and the other acts will become immediately applicable.*"

See also 91 Cong. Rec. 1444 (1945) (emphasis added):

"Mr. WHITE. Mr. President, is it not perfectly clear that the force and effect of these Federal statutes may be applicable and shall be applicable to whatever extent the State law fails to occupy the ground and *engage in regulation*? As I take it, there are two jurisdictions.

Mr. MCCARRAN. There always are.

Mr. WHITE. There is the State, authorized to act to whatever extent seems proper.

Mr. MCCARRAN. That is correct.

Mr. WHITE. Then the Federal Government can come in, and it does come in and may legislate beyond the limit of the State legislation.

Mr. MCCARRAN. To the extent that the State does not *regulate*.

Mr. WHITE. To the extent that the State does not *regulate*."

See also 91 Cong. Rec. 1443 (1945) (remarks of Senator Ferguson).

[49] The cases cited by petitioner (ULL Br. 33), in which lower courts have held that state antitrust laws of general applicability can satisfy the "state regulation" requirement, are wrongly decided. Those courts have failed to recognize the purposes of the Act, as described by this Court in *St. Paul* and *Royal Drug*, and do not even attempt to reconcile their holdings with the statutory language and legislative history.

ance" (emphasis supplied)). They have the general purpose of preserving a competitive system throughout the states' economy. Accordingly, they are not directed at the unique features of the insurance industry that were of special concern to Congress, and they provide no basis for immunity under the federal antitrust laws.

CONCLUSION

The decision of the court of appeals should be affirmed.

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